2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate.

In Defense of the Traditional Nurse

LISA H. NEWTON

In this essay Newton rejects the contemporary model of a nurse as an "autonomous professional" who can challenge physicians' authority and be a strong advocate for patients. She argues instead for the traditional notion of nurse as a caregiver *cum* surrogate mother who is subordinate to physicians. She insists that unambiguous lines of authority and clearly specified roles are essential to a well-run hospital and that in this setting physicians alone must be in charge when serious medical problems come up.

When a truth is accepted by everyone as so obvious that it blots out all its alternatives and leaves no respectable perspectives from which to examine it, it becomes the natural prey of philosophers, whose essential activity is to question accepted opinion. A case in point may be the ideal of the "autonomous professional" for nursing. The consensus that this ideal and image are appropriate for the profession is becoming monolithic and may profit from the presence of a full-blooded alternative ideal to replace the cardboard stereotypes it routinely condemns. That alternative, I suggest, is the traditional ideal of the skilled and gentle caregiver, whose role in health care requires submission to authority as an essential component. We can see the faults of this traditional ideal very clearly now, but we may perhaps also be able to see virtues that went unnoticed in the battle to displace it. It is my contention that the image and ideal of the traditional nurse contain virtues that can be found nowhere else in the health care professions, that perhaps make an irreplaceable contribution to the care of patients.

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and that should not be lost in the transition to a new definition of the profession of nursing.

A word should be said about what this article is, and what it is not. It is an essay in philosophical analysis, starting from familiar ideas, beliefs, and concepts, examining their relationships and implications and reaching tentative conclusions about the logical defensibility of the structures discovered. It is not the product of research in the traditional sense. Its factual premises—for example, that the "traditional" nursing role has been criticized by those who prefer an "autonomous professional" role—are modest by any standard, and in any event may be taken as hypothetical by all who may be disposed to disagree with them. It is not a polemic against any writer or writers in particular, but a critique of lines of reasoning that are turning up with increasing frequency in diverse contexts. Its arguments derive no force whatsoever from any writings in which they may be found elsewhere.

Role Components

The first task of any philosophical inquiry is to determine its terminology and establish the meanings of its key terms for its own purposes. To take the first term: a *role* is a norm-governed pattern of action undertaken in accordance with social expectations. The term is originally derived from the drama, where it signifies a part played by an actor in a play. In current usage, any ordinary job or profession (physician, housewife, teacher, postal worker) will do as an example of a social role; the term's dramatic origin is nonetheless worth remembering, as a key to the limits of the concept.

Image and ideal are simply the descriptive and prescriptive aspects of a social role. The *image* of a social role is that role as it is understood to be in fact, both by the occupants of the role and by those with whom the occupant interacts. It describes the character the occupant plays, the acts, attitudes, and expectations normally associated with the role. The *ideal* of a role is a conception of what that role could or should be—that is, a conception of the norms that should govern its work. It is necessary to distinguish between the private and public aspects of image and ideal.

Since role occupants and general public need not agree either on the description of the present operations of the role or on the prescription for its future development, the private image, or self-image of the role occupant, is therefore distinct from the public image or general impression of the role maintained in the popular media and mind. The private ideal, or aspiration of the role occupant, is distinct from the public ideal or normative direction set for the role by the larger society. Thus, four role-components emerge, from the public and private, descriptive and prescriptive, aspects of a social role. They may be difficult to disentangle in some cases, but they are surely distinct in theory, and potentially in conflict in fact.

Transitional Roles

In these terms alone we have the materials for the problematic tensions within transitional social roles. Stable social roles should exhibit no significant disparities among images and ideals: what the public generally gets is about what it thinks it should get; what the job turns out to require is generally in accord with the role-occupant's aspirations; and public and role-occupant, beyond a certain base level of "they-don't-know-how-hard-we-work" grumbling, are in general agreement on what the role is all about. On the other hand, transitional roles tend to exhibit strong discrepancies among the four elements of the role during the transition; at least the components will make the transition at different times, and there may also be profound disagreement on the direction that the transition should take.

The move from a general discussion of roles in society to a specific discussion of the nursing profession is made difficult by the fact that correct English demands the use of a personal pronoun. How shall we refer to the nurse? It is claimed that consistent reference to a professional as "he" reinforces the stereotype of male monopoly in the professions, save for the profession of nursing, where consistent reference to the professional as "she" reinforces the stereotype of subservience. Though we ought never to reinforce sex and dominance stereotypes, the effort to write in gender-neutral terms involves the use of circumlocutions and "he/she" usages that quickly becomes wearisome to reader and writer alike. Referring to most other professions, I would simply use the universal pronouns "he" and "him", and ignore the ridiculous accusations of sexism. But against a

background of a virtually all-female profession, whose literature until the last decade universally referred to its professionals as "she", the consistent use of "he" to refer to a nurse calls attention to itself and distracts attention from the argument.

A further problem with gender-neutral terminology in the discussion of this issue in particular is that it appears to render the issue irrelevant. The whole question of autonomy for the nurse in professional work arises because nurses have been, and are, by and large, women, and the place of the profession in the health care system is strongly influenced by the place of women in society. To talk about nurses as if they were, or might as well be, men, is to make the very existence of a problem a mystery. There are, therefore good reasons beyond custom to continue using the pronoun "she" to refer to the nurse. I doubt that such use will suggest to anyone who might read this essay that it is not appropriate for men to become nurses; presumably we are beyond making that at this time.

Barriers to Autonomy

The first contention of my argument is that the issue of autonomy in the nursing profession lends itself to misformulation. A common formulation of the issue, for example, locates it in a discrepancy between public image and private image. On this account, the public is asserted to believe that nurses are ill-educated, unintelligent, incapable of assuming responsibility, and hence properly excluded from professional status and responsibility. In fact they are now prepared to be truly autonomous professionals through an excellent education, including a thorough theoretical grounding in all aspects of their profession. Granted, the public image of the nurse has many favorable aspects—the nurse is credited with great manual skill, often saintly dedication to service to others, and, at least below the supervisory level, a warm heart and gentle manners. But the educational and intellectual deficiencies that the public mistakenly perceives outweigh the "positive" qualities when it comes to deciding how the nurse shall be treated, and are called upon to justify not only her traditionally inferior status and low wages, but also the refusal to allow nursing to fill genuine needs in the health care system by assuming tasks that nurses are uniquely qualified to handle. For the sake of the quality of health care as well as for the sake of the interests of the nurse, the public must be educated through a massive educational campaign to the full capabilities of the contemporary nurse; the image must be brought into line with the facts. On this account, then, the issue of nurse autonomy is diagnosed as a public relations problem: the private ideal of nursing is asserted to be that of the autonomous professional and the private image is asserted to have undergone a transition from an older subservient role to a new professional one but the public image of the nurse ideal is significantly not mentioned in this analysis.

An alternative account of the issue of professional autonomy in nursing locates it in a discrepancy between private ideal and private image. Again, the private ideal is that of the autonomous professional. But the actual performance of the role is entirely slavish, because of the way the system works—with its tight budgets, insane schedules, workloads bordering on reckless endangerment for the seriously ill, bureaucratic red tape, confusion, and arrogance. Under these conditions, the nurse is permanently barred from fulfilling her professional ideal, from bringing the reality of the nurse's condition into line with the self-concept she brought to the job. On this account, then, the nurse really is not an autonomous professional, and total reform of the power structure of the health care industry will be necessary in order to allow her to become one.

A third formulation locates the issue of autonomy in a struggle between the private ideal and an altogether undesirable public ideal: on this account, the public does not want the nurse to be an autonomous professional, because her present subservient status serves the power needs of the physicians; because her unprofessional remuneration serves the monetary needs of the entrepreneurs and callous municipalities that run the hospitals; and because the low value accorded her opinions on patient care protects both physicians and bureaucrats from being forced to account to the patient for the treatment he receives. On this account, the nurse needs primarily to gather allies to defeat the powerful interest groups that impose the traditional ideal for their own unworthy purposes, and to replace that

degrading and dangerous prescription with one more appropriate to the contemporary nurse.

These three accounts, logically independent, have crucial elements of content in common. Above all, they agree on the objectives to be pursued: full professional independence, responsibility, recognition, and remuneration for the professional nurse. And as corollary to these objectives, they agree on the necessity of banishing forever from the hospitals and from the public mind that inaccurate and demeaning stereotype of the nurse as the Lady with the Bedpan: an image of submissive service, comforting to have around and skillful enough at her little tasks, but too scatterbrained and emotional for responsibility.

In none of the interpretations above is any real weight given to a public ideal of nursing, to the nursing role as the public thinks it ought to be played. Where public prescription shows up at all, it is seen as a vicious and false demand imposed by power alone, thoroughly illegitimate and to be destroyed as quickly as possible. The possibility that there may be real value in the traditional role of the nurse, and that the public may have good reasons to want to retain it, simply does not receive any serious consideration on any account. It is precisely that possibility that I take up in the next section.

Defending the "Traditional Nurse"

As Aristotle taught us, the way to discover the peculiar virtues of any thing is to look to the work that it accomplishes in the larger context of its environment. The first task, then, is to isolate those factors of need or demand in the nursing environment that require the nurse's work if they are to be met. I shall concentrate, as above, on the hospital environment, since most nurses are employed in hospitals.

The work context of the hospital nurse actually spans two societal practices or institutions: the hospital as a bureaucracy and medicine as a field of scientific endeavor and service. Although there is enormous room for variation in both hospital bureaucracies and medicine, and they may therefore interact with an infinite number of possible results, the most general facts about both institutions allow us to sketch the major demands they make on those whose function lies within them.

To take the hospital bureaucracy first: its very nature demands that workers perform the tasks assigned to them, report properly to the proper superior, avoid initiative, and adhere to set procedures. These requirements are common to all bureaucracies, but dramatically increase in urgency when the tasks are supposed to be protective of life itself and where the subject matter is inherently unpredictable and emergency prone. Since there is often no time to re-examine the usefulness of a procedure in a particular case, and since the stakes are too high to permit a gamble, the institution's effectiveness, not to mention its legal position, may depend on unquestioning adherence to procedure.

Assuming that the sort of hospital under discussion is one in which the practice of medicine by qualified physicians is the focal activity, rather than, say, a convalescent hospital, further contextual requirements emerge. Among the prominent features of the practice of medicine are the following: it depends on esoteric knowledge which takes time to acquire and which is rapidly advancing; and, because each patient's illness is unique, it is uncertain. Thus, when a serious medical situation arises without warning, only physicians will know how to deal with it (if their licensure has any point), and they will not always be able to explain or justify their actions to nonphysicians, even those who are required to assist them in patient care.

If the two contexts of medicine and the hospital are superimposed, three common points can be seen. Both are devoted to the saving of life and health; the atmosphere in which that purpose is carried out is inevitably tense and urgent; and, if the purpose is to be accomplished in that atmosphere, all participating activities and agents must be completely subordinated to the medical judgments of the physicians. In short, those other than physicians, involved in medical procedures in a hospital context, have no right to insert their own needs, judgments, or personalities into the situation. The last thing we need at that point is another autonomous professional on the job, whether a nurse or anyone else.

Patient Needs: The Prime Concern

From the general characteristics of hospitals and medicine, that negative conclusion for nursing follows. But the institutions are not, after all, the focus

of the endeavor. If there is any conflict between the needs of the patient and the needs of the institutions established to serve him, his needs take precedence and constitute the most important requirements of the nursing environment. What are these needs?

First, because the patient is sick and disabled, he needs specialized care that only qualified personnel can administer, beyond the time that the physician is with him. Second, and perhaps most obviously to the patient, he is likely to be unable to perform simple tasks such as walking unaided, dressing himself, and attending to his bodily functions. He will need assistance in these tasks, and is likely to find this need humiliating; his entire self-concept as an independent human being may be threatened. Thus, the patient has serious emotional needs brought on by the hospital situation itself, regardless of his disability. He is scared, depressed, disappointed, and possibly, in reaction to all of these, very angry. He needs reassurance, comfort, someone to talk to. The person he really needs, who would be capable of taking care of all these problems, is obviously his mother, and the first job of the nurse is to be a mother surrogate.

That conclusion, it should be noted, is inherent in the word "nurse" itself: it is derived ultimately from the Latin *nutrire*, "to nourish or suckle"; the first meaning of "nurse" as a noun is still, according to *Webster's New Twentieth Century Unabridged Dictionary* "one who suckles a child not her own." From the outset, then, the function of this nurse is identical with that of the mother, to be exercised when the mother is unavailable. And the meanings proceed in logical order from there: the second definitions given for both noun and verb involve caring for children, especially young children, and the third, caring for those who are childlike in their dependence—the sick, the injured, the very old, and the handicapped. For all those groups—infants, children, and helpless adults—it **is** appropriate to bring children's caretakers, surrogate mothers, nurses, into the situation to minister to them. It is especially appropriate to do so, for the sake of the psychological economies realized by the patient: the sense of self, at least for the Western adult, hangs on the self-perception of independence. Since disability requires the relinquishing of this self-perception, the patient must either discover conditions excusing his dependence somewhere in his self-concept, or invent new ones, and the latter task is extremely difficult. Hence the usefulness of the maternal image association: it was, within the patient's understanding of himself "all right" to be tended by mother; if the nurse is (at some level) mother, it is "all right" to reassume that familiar role and to be tended by her.

Limits on the "Mother" Role

The nurse's assumption of the role of mother **is** therefore justified etymologically and historically but most importantly by reference to the psychological demands of and on the patient. Yet the maternal role cannot be imported into the hospital care situation without significant modification—specifically, with respect to the power and authority inherent in the role of mother. Such maternal authority, includes the right and duty to assume control over children's lives and make all decisions for them; but the hospital patient most definitely does not lose adult status even if he **is** sick enough to want to. The ethical legitimacy as well as the therapeutic success of his treatment depend on his voluntary and active cooperation in it and on his deferring to some forms of power and authority—the hospital rules and the physician's sapiential authority, for example. But these very partial, conditional, restraints are nowhere near the threat to patient autonomy that the real presence of mother would be; maternal authority, total, diffuse, and unlimited, would be incompatible with the retention of moral freedom. And it is just this sort of total authority that the patient is most tempted to attribute to the nurse, who already embodies the nurturant component of the maternal role. To prevent serious threats to patient autonomy, then, the role of nurse must be from the outset, as essentially as it is nurturant, unavailable for such attribution of authority. Not only must the role of nurse not include authority; it must be incompatible with authority: essentially, a subservient role.

The nurse role, as required by the patient's situation, is the nurturant component of the maternal role and excludes elements of power and authority. A further advantage of this combination of maternal nurturance and subordinate status is that, just as it permits the patient to be cared for like a baby

without threatening his autonomy, it also permits him to unburden himself to a sympathetic listener of his doubts and resentments, about physicians and hospitals in general, and his in particular, without threatening the course of his treatment. His resentments are natural, but they lead to a situation of conflict, between the desire to rebel against treatment and bring it to a halt (to reassert control over his life), and the desire that the treatment should continue (to obtain its benefits). The nurse's function speaks well to this condition: like her maternal model, the nurse is available for the patient to talk to (the physician is too busy to talk), sympathetic, understanding, and supportive; but in her subordinate position, the nurse can do absolutely nothing to change his course of treatment. Since she has no more control over the environment than he has, he can let off steam in perfect safety, knowing that he cannot do himself any damage.

The norms for the nurse's role so far derived from the patient's perspective also tally, it might be noted, with the restrictions on the role that arise from the needs of hospitals and medicine. The patient does not need another autonomous professional at his bedside, any more than the physician can use one or the hospital bureaucracy contain one. The conclusion so far, then is that in the hospital environment, the traditional (nurturant and subordinate) role of the nurse seems more adapted to the nurse function than the new autonomous role.

Provider of Humanistic Care

So far, we have defined the hospital nurse's function in terms of the specific needs of the hospital, the physician, and the patient. Yet there is another level of function that needs to be addressed. If we consider the multifaceted demands that the patient's family, friends, and community make on the hospital once the patient is admitted, it becomes clear that this concerned group cannot be served exclusively by attending to the medical aspect of care, necessary though that is. Nor is it sufficient for the hospital-as-institution to keep accurate and careful records, maintain absolute cleanliness, and establish procedures that protect the patient's safety, even though this is important. Neither bureaucracy nor medical professional can handle the human needs of the human beings involved in the process.

The general public entering the hospital as patient or visitor encounters and reacts to that health care system as an indivisible whole, as if under a single heading of "what the hospital is like." It is at this level that we can make sense of the traditional claim that the nurse represents the "human" as opposed to "mechanical" or "coldly professional" aspect of health care, for there is clearly something terribly missing in the combined medical and bureaucratic approach to the "case": they fail to address the patient's fear for himself and the family's fear for him, their grief over the separation, even if temporary, their concern for the financial burden, and a host of other emotional components of hospitalization.

The same failing appears throughout the hospital experience, most poignantly obvious, perhaps, when the medical procedures are unavailing and the patient dies. When this occurs, the physician must determine the cause and time of death and the advisability of an autopsy, while the bureaucracy must record the death and remove the body; but surely this is not enough. The death of a human being is a rending of the fabric of human community, a sad and fearful time; it is appropriately a time of bitter regret, anger, and weeping. The patient's family, caught up in the institutional context of the hospital, cannot assume alone the burden of discovering and expressing the emotions appropriate to the occasion; such expression, essential for their own regeneration after their loss must originate somehow within the hospital context itself. The hospital system must, somehow, be able to share pain and grief as well as it makes medical judgments and keeps records.

The traditional nurse's role addresses itself directly to these human needs. Its derivation from the maternal role classifies it as feminine and permits ready assumption of all attributes culturally typed as "feminine": tenderness, warmth, sympathy, and a tendency to engage much more readily in the expression of feeling than in the rendering of judgment. Through the nurse, the hospital can be concerned, welcoming, caring, and grief-stricken; it can break through the cold barriers of efficiency essential to its other functions and share human feeling.