

The nurse under physician authority

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Author's abstract

A medical centre is an institution established for a specific purpose: to facilitate the health and health-related welfare of the medical centre's patients. Within this institution, there are a variety of professionals who act and interact to serve this purpose.

Of particular interest is the interaction between physician and nurse. Generally, the nurse is thought to be under a certain obligation to implement a physician's orders unless there is good reason not to do so. This qualifier places a conflicting obligation upon the nurse not to implement some physician orders. How should a judgement about which orders there is 'good reason' not to implement be made?

I propose to approach this question through an analysis of the obligation the nurse has to implement the order of a physician, and the conditions under which the order does not pose such obligations. This analysis will consist of an examination of the obligation in terms of the purposive authority of the physician. For example, in the context of the medical centre, the physician's medical training qualifies her as best able to make determinations of what treatment would promote the patient's health. However, this purpose not only serves as the basis of the physician's authority, but also serves as a limitation upon the physician's authority (for example, an order which would harm the patient would not reflect the purpose for which the physician has been given authority). Thus, a philosophical investigation into the nature of the obligation to implement a physician's orders can help to clarify those occasions when a nurse should not implement an order.

The medical centre is an institution within which a wide variety of professionals act and interact in providing health-care treatment for the patient. Often, these professional roles overlap, and questions of 'domain', 'qualification', and 'authority' arise when professional assessments conflict. Of particular interest to this paper is the interaction between physician and nurse.

Key words

Authority; practical reason; medical ethics.

With the rise of technology in medicine, greater demands have been placed upon the physician, whose skills are being tested as never before. Specialisation has increased, and general practitioners have been forced to rely upon the skills and competencies of other professionals to an ever-increasing degree. Foremost among these other professionals is the nurse. Once virtually irrelevant to formulating a treatment plan for patients, the nurse's role has grown from that of virtual 'servant' to one of full colleague in the provision of health care, and now includes certain responsibilities to do with diagnosis and assessment, and even with the determination of range of treatments. For example, initial admission interviews are usually conducted by nursing staff, who interview the patient, identify many symptoms, and establish a base of information upon which health-care treatment will to a large degree be based; physicians rely upon the nurse to identify complications and changes in the condition of the patient, and there are a variety of 'nursing orders' which may be requested by the nurse. Originally limited to such things as weighing a patient, the scope of 'nursing orders' is rapidly increasing.

This increased responsibility for the nurse has led to a blurring of exactly what duties and obligations are attached to the nurse's professional role, particularly in the context of the nurse's relationship to the physician. While physicians have come increasingly to rely on the professional skills and competencies of the nurse, physicians retain the prerogative of prescribing and prohibiting treatment in formulating health-care plans for patients. When the physician gives an order, the nurse is under a certain obligation to carry out this directive. Divergence from the order, or failure to implement the order, is 'blameable'. Yet, at the same time, nurses are expected to spot mistakes in physician orders, and to take appropriate steps to remedy these mistakes when they occur.

This conflict of duties is further muddled by the ambiguous expectations of the nurse's supervisors and colleagues. When asked about the duty of a nurse in regard to physician directives, nursing administrators I interviewed gave answers which

ranged from a belief that the nurse should just do as told, to a belief that the nurse should not implement a directive with which she does not entirely concur. In practice, neither extreme seems plausible.

Physicians have mixed feelings about the responsibility of nurses in regard to nurses' assessments of mistakes. While they recognise the need for nurses to pick up on mistakes (such as decimal points being misplaced, etc), they are generally cautious about the idea of nurses operating as 'checks' on orders prescribed.

Most nurse managers maintain that the primary obligation of the nurse is the welfare of the patient, and that a mistaken order should be questioned. However, they also recognise that there is a need for a 'captain' of a health-care team, and accept that just as it will not do for the players of a sports team constantly to question the moves of their coach, so too nurses should not constantly question the orders of a physician.

How are we to understand these seemingly conflicting obligations which face the nurse in regard to carrying out the orders of a physician? I believe we must first understand the relationship between physician and nurse, and the moral obligations which arise from this relationship. We must recognise that the nurse-physician relationship exhibits the structure of 'rational authority'. By 'rational authority' I mean authority which imposes an obligation (to obey) because there are 'reasons for an action'. Rational authority has two primary characteristics: one, it is purposive in nature (one obeys authority for some purpose); and two, the authority's directive *replaces* independent weighing of reasons for action by the subject of the authority's directive (one acts for the reason that 'authority directed'). If we examine the nurse-physician relationship in this context, we may understand the nurse's obligation to carry out the orders of a physician, and from this the obligation to question a physician's order.

Rational authority

Rational authority is authority whose appeal for compliance is justified by reference to reasons for action. In this, it differs from authority based upon charisma, such as that of a public personality, faith, such as religious authority, or office, such as the authority of a police officer, or the president of the United States. In being justified by reference to reasons for action, rational authority is based upon some purpose, the achievement of which provides one with a reason to comply with the authority's directives. The purpose of the traffic law, for example, is to achieve order in transportation. This purpose provides the justification for the authority of traffic law: one has a reason to comply with the traffic law, for compliance will achieve order on the highways.

The second characteristic of rational authority is that it *replaces* independent weighing of reasons for action by the subject of the authority's directive. Once the authority of traffic law has been established, the subject no longer independently attempts to decide which side of the road to drive on. Rather, she makes this determination by reference to the directives of the traffic law. In this, rational authority involves a phenomenon known as 'second order reasoning'. This concept was discussed by Joseph Raz in a book entitled *Practical Reason and Norms* (1), and again explained in terms of authority in *The Morality of Freedom* (2). Raz explains the concept with the following example:

'Imagine the case of Ann who is looking for a good way to invest her money. Late one evening her friend tells her of a possible investment. The snag is that she has to decide that same evening, for the offer to make the deal will be withdrawn at midnight. The proposed investment is a very complicated one, that much is clear to Ann. She is aware that it may be a very good investment, but there may be facts which may mean it will not be a good bargain for her after all, and she is not certain whether it is better or worse than another proposition that was put to her a few days before and which she is still considering. All she requires is a couple of hours of thorough examination of the two propositions. All the relevant information is available in the mass of documents on her table. But Ann has had a long and strenuous day with more than the average amount of emotional upsets. She tells her friend that she can't take a rational decision on the merits of the case since even were she to try and work out the consequences of accepting the offer she would not succeed – she is too tired and upset to trust her own judgement. He replies that she can't avoid taking a decision. Refusing to consider the offer is tantamount to rejecting it. She admits that she rejects the offer but says that she is doing it not because she thinks the reasons against it override those in favour but because she cannot trust her own judgement right now' (3).

In the above example, Ann's reason for action is *not* that the action she takes is indicated by her evaluation of reasons. Rather, Ann's reason for action is that she has a reason not to act on her evaluation of reasons. Her mental condition is a second-order reason for disregarding what would normally be her reasons for action. This second-order reason *replaces* Ann's independent evaluation of the balance of reasons for action.

In the case of the nurse-physician relationship, the basis for the nurse's obligation to carry out a physician's order lies in the credentials of the physician. The physician's medical training places her in such a position – within the context of the purpose of the medical centre (to facilitate the health of the patient)

– that the purpose of the medical centre will best be achieved if the nurse takes the order of the physician as the proper way to determine treatment for the patient (rather than determining treatment herself). Of course, this will not be true in some specific cases, but generally the reason a patient goes to a physician is the expectation that doing so is the most likely way to get successful treatment.

Clearly, the foundation of the physician's authority is the medical training required in order to have the appropriate credentials to practise medicine. The physician's medical training is different from that of the nurse. While nurses receive training which sometimes overlaps with that of the physician, the training of the nurse is, for the purposes we are considering here (assessing physician mistakes), designed more to enable her to understand a physician's order and the effects which will result from various treatments, *than to enable her to evaluate which treatment is best*. By contrast, the physician's medical training is designed to enable the physician to make judgements as to what treatment is best, and to prescribe such treatments. The nurse's lack of medical training (and qualifications) to determine (and prescribe) the *best* treatment, coupled with the physician's medical training, provide the nurse with a *second order reason* to take the physician's directive as the proper way to determine treatment.

This is not to imply that a nurse's training is limited in scope to assessing a physician's orders. On the contrary, the nurse's training is a very complex and sophisticated education (one need only spend time with college students studying nursing to learn of the rigours and complexities of that field of study). Indeed, the nurses's role goes well beyond that of medicine, and the nurse may well be better qualified to make decisions about the patient's emotional welfare, for example, than the physician. But we are concentrating here upon conflicts between physician and nurse arising from the duties of the nurse in implementing a physician's orders (asking when it is appropriate for a nurse to dispute those orders). Therefore, we will limit our concern with the nurse's training to the areas where she is expected to serve in this role: implementing a physician's orders. I am also ignoring, in this paper, the duty of the physician to consult the nursing staff when determining treatment. While it is very likely that ethically, the physician should involve the nurse in the determination of treatment, we are not concerned with whether the physician has done so or not. We are only concerned with the *nurse's* duties when implementing a physician's orders. Here, the nurse's training differs from that of the physician in what each professional's training is designed to enable her to do. While the nurse's training is designed to enable her to understand the order in question and the effects which will result, it is the physician's training which is designed to enable her to assess the *best* treatment.

Limitations to physician authority

It is from the foundation of the physician's authority in her medical training, then, that we may determine the limitations inherent in the physician's authority. As we can see from the case involving Ann, a second order reason is *not* unjustified. For Ann, the fact that she was too tired to make a good decision was the basis of her 'second order reason' not to evaluate the reasons for and against making an investment. The nurse's reason to act as the physician directs is based upon the physician's medical training, and the purpose of promoting the patient's health. The first limitation of the physician's authority is derived from this basis of authority. The physician's directive, if it is to be taken as authoritative, must be relevant to the particular reasons for which the nurse appeals to the authority of the physician. Specifically, the physician's directive must be 'health-care-related'. The nurse should not accept as authoritative a directive from the physician to 'wash my car'. Such a directive draws no normative force from the reason to appeal to the physician for determination of action. Likewise, a physician's directive to do something which is not health-related (perhaps to provide a patient with television, or to behave in a certain manner when off duty) carries no normative force, as there is no reason to accept the physician's directive as a second order reason for determining what to do. I mean, of course, that there is no reason to accept his utterance, as a second order reason just *because he/she is a physician*. Of course, the physician might be my father, in which case I may, by virtue of that relationship, have some reason to take his directive as a second order reason.

The second limitation upon the authority of the physician is also derived from the 'reason to obey', but somewhat less directly. This limitation concerns the content of the physician's directive. If the directive does not reflect the 'reason to obey' (namely, the physician's medical training), the directive loses its normative force. For example, if the physician orders a drug in a dosage that will kill the patient, and it is known by the nurse that this will be the result, the directive clearly violates the very purpose for appealing to the physician's judgement. Likewise, if the physician is drunk, etc to the point that his/her judgement is unlikely to reflect the medical training upon which the 'reason to obey' is based, the physician's directive loses normative force.

Thus, we have a model in which the physician's medical education places her in a position such that what the nurse should do is to take the physician's determination of what treatment is best as the proper basis of determining treatment. Notice in this model two important elements: one, there is a reason to obey authority (the physician's credentials to best determine treatment); and two, that the physician's order replaces independent determination of what

treatment is best on the part of the nurse. The above analysis of the nurse-physician relationship exhibits the features of rational authority.

The judgements to be made by the nurse

From the above analysis of physician authority and limitations upon this authority, it becomes clear what sorts of things a nurse may be held morally responsible for in the face of a physician's order. These things consist of judgements as to a: whether the physician's order is appropriate (relevant to the health care of the patient, and b: whether the physician's order falls within an acceptable 'range' in that it reflects the basis of the physician's authority (and whether the physician is in such a condition that her judgement will reflect the medical training from which she derives her authority).

A judgement as to whether an order reflects the first part of b, ie reflects the basis of the physician's authority sounds as if it might be theoretically difficult to make. Fortunately, however, such a judgement can be made. Nurses, as well as physicians, go through medical training in order to be licensed to practise. Only nurses who have the appropriate credentials may carry out certain types of orders (for example administering a drug). Because of the medical training required in order to be licensed to carry out particular orders, it is reasonable to assume that a nurse who is implementing a particular order is qualified to evaluate whether or not the order falls within an acceptable 'range'.

An example of the fact that we *do* make such assumptions of competency can be found in law. In the case of *Norton v Argonaut Insurance Co* (4), the parents of an infant girl sued for wrongful death when their daughter died of an accidental overdose. Not only was the physician found negligent, but the nurse was also found negligent for attempting to administer a drug with which she was unfamiliar.

What this requires is the disqualification of some nurses from carrying out certain orders. Since in obeying authority the subject of the directive is responsible for a: judging whether there is a reason to take the authority's directive as a second order reason for action, and b: judging whether the directive falls within an acceptable 'range' (so as to reflect the physician's medical training); a nurse may be held responsible for these judgements. If a nurse is not qualified to make such a judgement, he/she should not implement the directive. We see this in practice with the credentials of RNs (Registered Nurse) and LPNs (Licensed Practical Nurse). Some LPNs, who have a different and lower level of medical training than the RNs, do not have the appropriate credentials to perform the same tasks as RNs (for example, administering drugs). (There are different credentials within the LPN profession: many LPNs receive the appropriate training and have the credentials to administer drugs.)

Conclusion

I hope that the above analysis of authority and the nurse-physician relationship helps to clarify the responsibilities of the nurse (and the types of things for which the nurse may properly be held morally responsible) under a physician's orders. The nurse is morally responsible for judging whether a directive by a physician should be taken as a second order reason for action, and is morally responsible for judging whether a given directive falls within an acceptable 'range'.

Where does this leave the nurse in regard to questioning a doctor's order? There are certain grounds upon which a nurse should question an order. A nurse generally should not question a physician's order because she feels that drug 'X' is better than drug 'Y', or because she feels that the order is not 'really' needed. It is not proper for the nurse to question an order solely on the grounds that her assessment of what the treatment should be differs from that of the physician. Such a limitation would undermine the authority of the physician, because to implement a directive only if it corresponds with one's own judgement is in effect not to recognise the directive as imposing obligation.

The acceptable criteria for questioning a physician's order are that it is not relevant to the physician's medical training, or does not reflect basic competency (for example the physician's judgement is impaired by drink or is, upon the nurse's understanding of the drugs involved, not reflective of the physician's medical training). If the order is inappropriate, or if the order does not fall within an acceptable range (so as not to reflect the reason to take the physician as authoritative), the physician's order loses its normative force.

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References

- (1) Raz J. *Practical reason and norms*. London: Hutchinson, 1975.
- (2) Raz J. *The morality of freedom*. Oxford: Oxford University Press, 1986.
- (3) Raz J. *Practical reasoning*. Oxford: OUP, 1978: 130. Raz also offers several other examples of second-order reasoning, see reference (1): 37–39.
- (4) This case is discussed in Creighton H. *Law every nurse should know* (4th ed). Philadelphia: W B Saunders and Co, 1981: 334.

Obituary

Dr R D Catterall, CBE, FRCP, 1918–1993

It was Duncan Catterall's popularity with students that caused our paths to cross. In the late 60s I had recently established the London Medical Group in an attempt to introduce medical ethics into medical education. He had recently been appointed to the Middlesex. When they appreciated what I was trying to do, some Middlesex students said I ought to meet Dr Duncan Catterall.

When I went to see him at James Pringle House (in clericals – I leave you to picture the scene) it was to be the beginning of twenty-five years' collaboration.

I have an enduring memory of the first of many meetings in his office. Always the immaculate white coat, always the shining desk top, devoid of papers, always the total attention and the smile, and that gracious welcome which put one at ease.

He could immediately appreciate the aims of the LMG – a student group for the study of issues raised by the practice of medicine which concern other disciplines – and agreed to serve on its Consultative Council, which, from 1973 until he retired, he chaired.

It was my task to translate topics chosen by students into an annual programme of symposia which involved identifying some two hundred consultants and others. There was no way that I, knowing little of the medical world, could hope to succeed in this task, without taking advice. But what I received from Duncan Catterall was total commitment to the exercise. Year after year, at a

crucial stage in the preparation of the following year's lecture list, he would put aside time to go through, in great detail, each of some forty-eight symposia, to ensure the highest possible standard. His concern was for excellence, and his care was for the students involved.

Without his friendship and support and his effective involvement of others, I have no doubt at all that the LMG would not have developed as it did. He served on the Governing Body of the Institute of Medical Ethics and was a founder member of the Editorial Board of the *Journal of Medical Ethics*.

I greatly enjoyed his company. He was urbane and debonair. He was an excellent chairman. He enjoyed good conversation and table talk, and when the LMG adopted the practice of students entertaining the lecturers to dinner, instead of a fee, he was at once at home in this milieu.

It seems only yesterday that we met at the RSM for lunch. He was very much himself and better than at our previous meeting. The wine was excellent and the conversation flowed until he tired and we parted.

It occurred to me afterwards that he was saying Goodbye. May he rest in peace.

An appreciation by the Dean of Rochester, The Very Revd Edward Shoter, at the Thanksgiving for the Life and Work of Duncan Catterall at the Middlesex Hospital on 26th May, 1993.