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Doctors and nurses once more – an alternative to May

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Abstract

It is argued that promissory obligation arising from the contract of employment offers a simpler and less contentious explanation and justification of the doctor-nurse relationship at work, than does May's proposal of second-order reasons (1).

The second-order reason position is rejected as the norm for that relationship, and in the exceptional case, where it is admitted, shared employee status is identified as primary validator of a doctor as locus of rational authority.

Finally, a brief case is made for a more precise vocabulary to describe the doctor-nurse relationship, as a contribution to more collegial relations.

May (1) argues that the philosophical explanation and justification of the nurse's obligation to carry out the doctor's instructions with reference to the treatment of patients can be construed from the notion of second-order reasons for action, as proposed by Raz (2). There is, however, an alternative approach to the obligation relationship which is both simpler and, less contentious (3).

The model is based on the contract of employment, as it applies in the UK but the principles of which are as apt for the nurse and doctor in the United States, which is the context of May's proposals. This perspective will shed light on the nature of the relationship of doctor and nurse while 'in course of employment', and on the moral and legal underpinning of the nurse's behaviour in carrying out instructions from doctors. It further suggests that the obligation of the nurse to do so derives essentially from rights and duties involving nurse, employer, and patient directly, and nurse and doctor only coincidentally.

The doctor-nurse relationship at work derives from, and is made possible by, the contract of employment which each has with a common employer. The decisions and behaviour of each to the other while at work must be informed by the moral and legal nature of that contract.

Key words

Doctor-nurse relations; second order reasons; contract; promise; obligation.

The legal basis of the contract is the relevant statute and common law surrounding a fundamental exchange of promises which constitute the necessary legal consideration, ie, a promise to work for a promise to pay. From that basis a matrix of rights and duties emerges binding employee and employer.

A promise of course is not simply a legal phenomenon, it is also a moral fact giving rise to obligation: 'it is an affirmation of performance, and a statement that others may rely on the doing of the act' (4).

The terms of such a contract then have moral as well as legal force, and two such terms are relevant to this argument. One is that the employee will carry out the reasonable instructions of the employer, another imposes a duty of trust, ie, the employee will do nothing to undermine his or her employer's business (5).

The reasonable conclusion then is that both doctor and nurse are legally obliged, and have a moral obligation to assist each other in the successful treatment of patients, which is their employer's business and the reason that they are employed.

From the nurse this requires willingness to deploy knowledge, skill and experience to assist the doctor reasonably in the treatment of patients. Equally the onus is on the doctor to be willing to respond, for instance, to requests from nurses to consider further examination of a patient, or modification of treatment and, generally, to deploy his particular knowledge and skill to resolve problems requiring that expertise.

It is evident that the legal duty and the moral obligations of doctor and nurse to co-operate in the treatment of patients are not different in kind between the two, and derive from the duties and obligations which link both with their employer.

Turning to the problem, as May sees it, of justification for nurses questioning doctors' instructions (6); such questioning may from time to time be essential to fulfil the duty of trust to the employer which rules out behaviour likely to undermine his business. That is not a legal duty only but derived from the promissory obligation underlying the contract.

Again it is not different in kind for doctor or nurse. The consequences of either failing to exercise his or her best judgment as to the reasonableness and safety of treatment in which both are involved could be precisely to damage the employer's business when for whatever reason, either doctor's instructions or nurse's behaviour are apparently unsafe or unreasonable.

Certainly nurses can exercise constructively critical judgment of medical instructions only within limits determined by education and experience, which will vary between individuals, but contractual obligations require that they be prepared to do so, and do not accommodate the more comfortable acquiescence implicit in the second-order position as proposed by May.

That said there are situations, for instance some emergencies, some innovative treatment strategies, in which nurses will carry out doctors' instructions while not being able, by virtue of deficient knowledge or experience, to make an informed judgment about the safety and reasonableness of the procedures, and here, May's proposals of a second-order reason position for the nurse may be relevant. That is, having reasonable grounds to perceive the doctor as a locus of rational authority, and recognising his contribution as purposive, the nurse is prepared to act on the doctor's instruction.

What is important here of course is the question of the grounds on which the nurse rests her faith in the particular doctor as a rational authority. For May it seems to be sufficient that the nurse believes the individual is a doctor, and has therefore benefited from a medical education (7).

More, however, is required, because a nurse may be ignorant or indeed misled about qualifications; it would be the exception rather than the rule for nurses to have specific knowledge of the background of the medical staff with whom they work. The firm ground on which acceptance by the nurse of the doctor's competence must rest primarily is a reasonable belief in the good faith of her employer in having recruited this individual to work as a doctor in the situation in which she finds herself, and awareness of the employer's sensitivity to his common law duty to patients to employ competent staff for their care (8).

It is important to May's proposals that the doctor is acknowledged as rational authority for the purposes of second-order reason rationale, by virtue of his medical education, but he does not acknowledge that the particular doctor is authenticated in that role, for the nurse, by virtue of his employee status.

It is the shared reality of that status with a common employer which also and essentially validates this exceptional dimension of the nurse-doctor relationship.

Briefly, what is contended in this paper is that both doctors and nurses, by virtue of their contract of employment, are legally obliged, and have a moral obligation, to co-operate from their respective expertise in the treatment of patients; that the adoption of a second-order reason position by nurses would not be acceptable as the norm in the context of such a contract; and that in exceptional cases where it is warranted, the validation of a doctor as the locus of rational authority by the nurse rests essentially on their shared status as employee.

Finally, choice of language in this discussion is crucial for accurate perspectives and rational debate. The phrase 'doctors' orders' for instance, is ambiguous.

It can be taken to mean the prescriptions or advice of the doctor with regard to treatment, or a directive of such authority that only obedience will be an appropriate response.

That second interpretation is wrong, in so far as the doctor (unless he is the employer, or the manager) has no such authority over a nurse. In the unusual case of a nurse refusing to carry out a doctor's 'orders' the doctor must have recourse to the nurse's senior and persuade that individual to direct the nurse to implement his instruction.

Both doctor and nurse can have proper expectations of mutual co-operation and assistance, but can demand it morally only subject to the other's moral judgment, and authoritatively only with the co-operation of the other's manager or employer.

'Assist'; 'help'; 'co-operate'; 'implement', will for most purposes more accurately reflect the collegial nature of the nurse-doctor relationship, and are less contentious. Intelligent co-operation and mutual regard for patient well-being provide the better basis for treatment and care.

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