

Medical authority and nursing integrity

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This paper explores the respective legitimacy or illegitimacy of medical authority over nursing work. The analysis makes use of Joseph Raz's ideas concerning the nature of authority. Various scenarios are considered which lend themselves to differing interpretations, and the conclusion reached is that acting in accordance with legitimate medical authority enhances rather than compromises the nurse's professional integrity. Difficulties, however, may lie in disentangling legitimate from illegitimate attempts to control nursing work.

Before embarking on this inquiry, it needs to be made clear that I do not intend to explore the question of whether the delivery of health care requires an authoritative structure, nor do I propose to examine the conceptual nature of authority in general. The focus of this paper is narrower and it will be assumed that since in fact people do have authority over other people in the delivery of health care, this structure is capable of justification. My intention is to examine the doctor-nurse relationship from the perspective of the doctor's authority over the nurse and then to try to determine when this might be a legitimate claim, such that the nurse ought morally to carry out the doctor's orders and when it might be said to be illegitimate, such that she should ignore the instruction. Four illustrations follow:

1. A staff nurse awaits the doctor's signed prescription for an antibiotic for a child's pneumonia before administering it. She notes that it is a drug with which she is not very familiar. She asks the doctor why he is using it and after he has gone, checks in her pharmacopoeia to see if the doctor's prescription seems to be in line with the paediatric dose suggested. She also looks up the side effects. Having satisfied herself on these matters, she administers the drug.
2. An experienced burns unit sister obtains another post in a similar specialty. Here she learns that the consultant wants a certain skin-care procedure to be followed for his patients. Where the sister worked previously, a different protocol was used, one that she felt successfully promoted healing. She has reservations about the new approach she is being asked to use but cannot base these on actually having used this method before.
3. A clinical nurse specialist who runs her own leg ulcer clinic suddenly finds that whereas most of the general practitioners (GPs) do not interfere in her management of this, a new GP partner in the practice is constantly instructing her in what dressings he thinks she should use for his patients.
4. A staff nurse on a surgical ward is instructed by the senior registrar on no account to tell a patient in their shared care that he has cancer of the colon and a poor prognosis.

No claim is made to have captured above, the full range of possible expressions of medical authority over nurses but the examples are sufficiently diverse to provide a basis for discussion. They will be considered in turn.

In the situation of prescribing medicine, the doctor is expected to choose the right drug and the nurse is expected to give it, provided she has no professional reservations about

doing so. From the doctor's point of view, deciding on the right drug is a matter of determining the one that will be best for the patient, with the proviso that sometimes there will be limiting factors to do with availability or cost. Such a judgment requires pharmacological and biochemical knowledge, combined with knowledge of recent research on the drug's efficacy, side effects, etc. In addition, the doctor must weigh her own experience of the prior use of such medication on other patients and include in the equation, her specific knowledge of the needs and past medical history of the specific patient before her. In ordinary circumstances, the doctor expects that having prescribed the drug, it will be given to the patient by the nurses at the times and in the amount prescribed. This expectation is implicit in the relationship between the doctor and the nurse and no checking normally follows.

The nurse, on the other hand, is not expected to share the doctor's knowledge of drugs and their reactions, although she is expected to have sufficient grasp of these things to recognise unusual drugs and dosages and thus to query them if she is unsure. She must also have some grasp of side effects to alert her quickly to a patient's adverse reactions. In addition, the nurse is expected to address herself swiftly to any deficiencies in the above by asking for information or looking it up. The nurse does not perceive herself to be deficient as a nurse because she cannot prescribe but she would expect of herself, as would the United Kingdom Nursing and Midwifery Council, that she would refuse to give a drug (and inform the doctor and her own nurse manager of this) if she was worried about the consequences of its nature or its dose for the patient. The question now becomes how to describe this kind of situation conceptually and morally.

Several of us have attempted to do so.¹⁻⁴ May uses Raz's^{5, 6} analysis of practical authority and considers this to be a helpful way of both illuminating the nature and the limits of a doctor's authority over nurses in such a context. May⁷ says:

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").

One advantage of Raz's analysis for the context of nurse-doctor relations is that he does not think that legitimate authority necessarily compromises the integrity of those with a duty to obey, in fact he thinks the reverse.⁸ May's ideas, therefore, may be very useful but he seems to misapply a Razian analysis to the above physician-nurse context.

According to Raz⁹ an authority is legitimate "only if there are sufficient reasons to accept it" by which he means that there are "sufficient reasons to follow its directives regardless of the balance of reasons on the merits of such action". Raz¹⁰ considers there to be two common kinds of practical authority, one which concerns "knowledge and experience" and the other which concerns the necessity for coordination and "social cooperation" for the achievement of social goals. As he states, expertise alone is not sufficient to warrant a person's acceptance of authority because advice can justifiably be ignored in such circumstances but advice can become imbued with authority if the recipient's goals warrant that it should.¹¹

In health care, nurses' and doctors' goals regarding the function and purpose of their respective roles are powerfully aligned. I say "aligned" rather than "the same" because whilst both are committed to the best interests of their patients, which includes the relief of suffering and recovery, where recovery can be hoped for, each discipline and the individuals within them may interpret what counts as "the best interests of the patient" differently.

The nurse who gives patients their prescribed medication gives it because she is expected to do so but the belief which allows her to accept this authority is the belief that in so doing she will be acting in the patient's best interests; a view which to some extent she must take on trust since she is not capable of making an independent assessment. It is Nash⁴ who, I think rightly, suggests that the contract of employment assists the nurse in developing this trust—that is, she does not have to evaluate the doctor's competence for herself but can take it on trust that he is fittingly employed for the job which he must perform. This, however, does not provide a safeguard against mistakes of prescription and in administering a misprescribed drug, the nurse may share moral and legal culpability with the doctor. The nurse, therefore, has to be vigilant.

To describe this process in a Razian framework, May¹ suggests that as a legitimate authority on the matter of prescribing because of his greater knowledge, the doctor provides second order, pre-emptive reasons for the nurse to obey him. This is of course to be understood against a background where the doctor has an institutional right and corresponding responsibility to prescribe such treatments. By a pre-emptive reason, Raz¹² says he means "a reason which displaces others" and by the notion of "second order" he is drawing attention to a different and higher level of reasons from the first order level. There is a relationship of dependency between first order and second order reasons if authoritative orders are to be considered legitimate.¹³

The difficulty that I have with this formulation in this context is that as there are no obvious first order reasons for the nurse to have an opinion, since she is neither expected to do so nor does her education equip her to, one wonders what sense can be given to second order reasons. They have nothing to pre-empt. One might say that they pre-empt the possibility of the nurse having an opinion of her own on the matter but for most staff nurses such an idea is entirely speculative. This suggests to me that an unnecessarily complicated formulation of authority is being used to capture something much simpler. In my brief reply to May's article, I argued that the nurse's position in relation to the physician is of the minimalist kind that Raz sees contained in Friedman's views.¹⁴ Raz states:

... the minimalist interpretation maintains that they are willing to obey if they have no judgment of their own on the merits of performing the required action. They will not then defer decision until they form their own judgment.¹⁵

Raz rejects this minimalist formulation as being too weak to capture the fact that people may be bound by authority "regarding issues on which they have firm views".¹⁵ Whilst this would seem to be true, it is not a conclusive argument against Friedman, for it leaves open the possibility that various models are needed to explain the role of practical authority in different contexts: a point openly accepted by Raz.¹⁶

One is thus left with the question as to what "nursing with integrity" requires of the nurse in the above context. From the preceding analysis, it would seem to require that she obey medical prescribing authority, except where she has reason to doubt the credentials of the doctor to have the expertise he claims to have, or where she thinks an error of dosage or type of drug may have been made. Professional integrity seems to require that she ought not to give any drug if she has such doubts but if such doubts remain, in acknowledgement of the responsibility the doctor carries and his ordinary expectations of her as a nurse, she would have a duty to inform him and also her nurse manager as her immediate employer.

In the second example, of the burns unit sister, there is an important difference between this and the first example. Here the sister has expertise in her own right and can therefore be expected to have first order reasons, resulting in her own conclusion about which treatment is preferable. Her views then clash with the consultant's views. What should she do? She might decide to keep her opinions to herself and simply fit in, at least for a while. Alternatively, she may feel obliged to discuss her views with the consultant concerned, in an attempt to either be persuaded by him of the reasonableness of his approach or to hope to change his perspective to accommodate hers. What she would have to acknowledge is that in health care, there may be more than one good way of doing things and that neither she nor the consultant may know all there is to know about the efficacy of each approach but that what each values is their experience. In such a context, if the consultant persists, despite listening to her objections, in insisting that she follow his protocol then unless she can prove that his way actually causes damage to patients, the sister would be obliged to proceed in the care of his patients in the way he requires or go and work elsewhere (as would be the case with those psychiatric nurses who object to electroconvulsive therapy on moral grounds).

One reason for her compliance would be that the consultant, as the person with overall responsibility for the clinical care for the patients he admits and discharges, has legitimate practical authority of the coordinating kind. In addition, his knowledge and experience give him grounds to expect that treatment orders that are in line with this are legitimate and therefore ought to be followed by the nurse if she wants to stay working in his unit. The consultant's instructions thus give the sister, second order pre-emptive, exclusionary reasons (reasons which exclude some or all first order reasons from having weight) to cease weighing the pros and cons for herself on this matter and to do what he says.

Unlike example one, this situation does seem to lend itself to a Razian kind of analysis for I think Raz is right in his insistence that legitimate commands should not be understood as providing an additional reason amongst the pre-existing first order reasons for obedience, thereby simply altering the weight of the ensuing balance. Rather, his claim is that such commands or instructions disqualify the first order reasons in favour of doing something else, from counting at all. The sister in the example has to relinquish making her own independent judgment on the matter to fall in with the consultant's requirements. This, however, as Raz¹⁷ is at pains to point out, does not mean that the first order reasons she originally had in support of her views simply disappear. On the contrary, the sister might be determined to find better evidence to support her case and only be prepared to comply until she finds such evidence, or she might be prepared to wait until this consultant retires and somebody new is appointed whose ideas she might hope to influence more successfully.

Many different resolutions are possible but none, I think, straightforwardly jeopardises the sister's professional integrity. This would only be threatened if she sincerely felt she was being asked to harm patients or being asked to do something useless to them such that it would make the nurse-patient relationship deceptive. Maintaining her integrity does I think also require the sister to voice and explain her dissent and not simply comply with the consultant's orders as the easier (for her) option. This is because people working in a team owe it to each other to try to work honestly together in the interests of their mutual goals, in this case the wellbeing of patients in their shared care. There is some empirical evidence to support this normative view.¹⁸⁻²¹

The third example is similar to the second in so far as both nurses can rightfully claim expertise and both are in some conflict with doctors, with whom their professional circumstances oblige them to either work or change their jobs. It differs, however, in that the nurse in this context has done a specialist course in the management of leg ulcers which places her in a position to have legitimate prescribing powers concerning topical (to the skin) applications of creams and impregnated dressings etc. The GPs in the primary care practice have implicitly acknowledged her expertise in this respect by permitting her to establish and run her own clinic. There is, however, a dissenting voice in the new partner to the practice. Does he therefore have the right to instruct the nurse in how she is to manage the ulcer care of his patients and to expect that she will obey him?

Here, the word "permitted", used of the way in which this nurse's practice is conducted in this context demonstrates how the idea of doctors carrying overall responsibility and the coordinating function for the care of patients, remains constant. Unlike a radical midwife, the nurse has not set up her own independent practice. She does have expertise, however, and of a kind likely to be equal to if not greater than that of the average GP on the subject of the care of leg ulcers. The doctor in this instance, therefore, cannot claim that his authority necessarily comes from superior expertise. Nevertheless, he could claim that the legitimacy of his authority springs from the dimension of his overall coordinating responsibility and he may remind the nurse that she is in fact employed by the doctors as a collective partnership, thereby obliging her to do what he says. The question here is about establishing the legitimacy of the authority because if it is legitimate then what ensues will follow the pattern described in example two.

The employment issue is one that cannot be denied. It is of the nature of the relationship between employer and employee that the former has some degree of legitimate authority over the latter but in the example, it is not the case that one doctor in isolation can straightforwardly exert pressure from this basis. If he dislikes what the nurse is doing and wishes to exert his authority as a manager over her, he has at least to persuade the other GPs in the practice to agree with him. This they would seem unlikely to do since they have already endorsed the value of the nurse's work and their faith in her professional judgment. Discussion amongst the doctors might therefore lead to a sceptical GP being persuaded to allow the nurse to carry on unimpeded. Suppose, however, that the dissenting doctor does not use any lever of being an employer but simply says that since his patients are his overall responsibility, he would like her to treat them in the way that he recommends. The nurse would, I think, be quite within her rights to refuse to be bound by this, although she would have a professional obligation to listen and consider the GP's arguments first. She could, for instance, say that she too has responsibilities to patients to act in their best interests and since her expertise equips her to have a sound view on the matter, she cannot do something she feels would oppose this. She could politely suggest that if the GP in question continues to feel strongly about the matter, he should perhaps run his own clinic for his patients.

It would seem, therefore, that the nurse in such a context would consider the doctor not to have legitimate authority over her practice, although she might concede that ultimately the GPs collectively, as her employers, could stop her practising in this way. She might also concede that maintaining workable collegial relations is desirable for those who have to work together and in the interests of patient care. She might, therefore, not consider herself bound by this GP's authority but nevertheless go along with what he asks for a time, thinking that this matter might more profitably (from her point of view) be raised again when he is less new in the situation and has had more time to realise her worth. Such a temporary compromise might mean that some patients receive what the nurse considers to be less than ideal care for a time. The moral justification for this would presumably be consequential, along the lines of some people's care being less than ideal to try and ensure that in the future more will be. Not everyone will be morally persuaded by an argument of this type and for those who are not, there is an issue here of the nurse unacceptably compromising her professional integrity.

The fourth example is, unfortunately, quite a common one. Yarling and McElmurry²² describe a situation where "a physician ordered a nurse not to disclose to a terminally ill patient her prognosis, even though the patient had asked the nurse direct questions". They go on to quote from a previous paper by Yarling²³ on the nurse's reactions:

She was very uncomfortable lying to a patient who had come to trust her. However, ... she was hesitant to act contrary to the wishes of the family, the physician, and the head nurse; and she was not sure what her legal rights were in the situation.²⁴

Earlier in their article Yarling and McElmurry²⁵ refer to a physician who was of the view that in a similar situation "... the nurse's relationship with the patient is different than the physician's. It does not require independent moral judgement by the nurse". This attitude is incoherent for it is of the nature of any relationship between human beings that moral concerns and therefore judgments will enter. The possibility of being kind or being cruel is always present and no more so than when one person has power over another, as the healthy inevitably do over the ill who depend on them for help. The doctor's attitude, however, does capture why it might be that some doctors might consider it their right to try to control what goes on in the nurse-patient relationship. Do they have any legitimate authority to do so?

It is not difficult to imagine what might bother a doctor about this matter. There might be a legitimate concern that a junior nurse, who only knows a partial truth about the patient's diagnosis and prognosis and who then takes it upon herself to inform the patient of his predicament, may cause unnecessary distress. Due to their proximity to patients, however, nurses are most likely to be the people patients asks for such information. A doctor who is concerned about this matter could be said to have two responsibilities. One would be to try to make sure that he delivers the news, and preferably with a senior nurse present, so that all parties know what has been said. The other is to try to make sure that all nurses on the ward have a clear understanding of the patient's situation. Neither of these responses alone will avoid the difficulty of a patient who clearly does not want to know his diagnosis at the time the consultant is prepared to tell him but who then subsequently asks the nurse as she is doing his bed bath. A way out of this difficulty, however, cannot be for the doctor to require that the nurse engage in a dishonest relationship with her patients, thereby compromising her personal and professional integrity.

Ladd²⁶ has an interesting response to situations such as the above where a person may be thought to have exceeded the legitimate boundaries of their authority. He says:

Ethically, the correct response to the order to lie to a patient is either that the doctor has no right to tell the nurse what to do—that is, the doctor has no authority—or that the doctor has no right to tell the nurse to do that particular thing—that is, he has exceeded his authority. In other words, the nurse is not required to defend her refusal with a counterargument, for example, to the effect that she has a duty to the patient that conflicts with her duty to the doctor. For, in such cases, she has no duty to the doctor at all.²⁷

What I think the nurse might say is that whereas the doctor properly has a degree of clinical authority over her, as demonstrated in the preceding examples, he does not have moral authority over her. This would seem reasonable but it presupposes that separating the moral from the clinical is a feasible thing to do. If the moral and the clinical tend to fuse in health care, it may be impossible to perceive each separately. In the illustration just given, where a nurse may be instructed in how she is to relate to the patient, it is not too difficult to question the clinical justification for such a stance but the doctor concerned may genuinely think that his attempt to control the nurse-patient relationship is in the patient's overall best interests. He may, for instance, believe that if a patient comes to learn of his poor prognosis, this may impede his immediate recovery from surgery. Others might argue the reverse and say that if the patient hints at or directly asks about his prognosis, then for the patient not to receive a straight answer will in itself contribute to anxiety and possibly interfere with recovery. Different moral, and their related clinical, understandings can and do prevail here and they reflect different understandings about the mind and what is necessary for mental adjustment and flourishing. It is not difficult to see, therefore, how the nurse may become confused in such contexts and not know what to say or do.

These sorts of situations can become very complex. Imagine for instance, a stoma care nurse who works closely with a surgeon who does a considerable amount of bowel surgery for severe bowel disease such as ulcerative colitis. Such patients may end up with a colostomy or even an ileostomy and as part of their preoperative preparation, they would routinely see the stoma care nurse. A new form of surgery is being pioneered for these conditions, one which does not result in a stoma. The stoma care nurse knows that the surgeon she works with never mentions this option to his patients. She has discussed it with him and he says that this new surgery has yet to prove its efficacy and early results suggest a fair proportion of failures such that people may end up ultimately having to have the conventional operation. He is not trained to do the new surgery and so extracontractual referrals would be needed. He says that he also suspects that patients would be attracted to the cosmetic advantages of the new approach which may blind them to its uncertain efficacy.

The nurse can see the point of these observations but feels that, nevertheless, patients have a right to know all the options open to them and whilst health care professionals should rightly try to guide their choice, if an individual opts for taking a risk, they should be free to do so. Can the surgeon forbid the nurse from mentioning this to the patients? Would it be a legitimate use of his authority? Here one sees again how neatly the moral and the clinical seem tied together. If the nurse decides that she has no reason to obey this kind of directive, she does at least have to consider two things, the first is the surgeon's right to know this, since he has overall responsibility for his patients' care and the second involves the implications for the patient's trust in the surgeon; a not insignificant issue for someone about to embark on major surgery.²⁸

To return to the Razian analysis, the stoma nurse may decide that whereas the surgeon's embargo on her giving

patients certain kinds of information does not give her second order, exclusionary reasons to ignore her first order principles which say she should, nevertheless, the surgeon's reasons for his diktat still continue to provide the nurse with further first order reasons to consider. A Razian analysis of the legitimacy of authority may also offer an advantage in that it does not require mental gymnastics to try to separate the clinical from the moral. For Raz "the justification of the binding force of authoritative directives rests on dependent reasons" and he goes on to say:

Because authorities do not have the right to impose completely independent duties on people, because their directives should reflect dependent reasons which are binding on those people in any case, they have the right to replace people's own judgment on the merits of the case. Their directives pre-empt the force of at least some of the reasons which otherwise should have guided the actions of those people.²⁹

Edmundson³⁰ draws attention to the fact that Raz³¹ concedes that "any practical inference that can be justified at all can be justified with reference to first order reasons alone" and that this opens up the possibility that the idea of exclusionary reasons collapses. Raz, however, maintains that only appealing to first order reasons is "not the way we actually go about justifying our practical conclusions".³² Accepting the Razian analysis, one might therefore argue that where doctors attempt to use their authority to control the nature and content of nurse-patient relationships, their authority is illegitimate because it fails to reflect dependent reasons. This would not mean, however, that the nurse should then ignore what the doctor says. It would seem that the doctor's point of view should at least be weighed in the balance amongst the nurse's other first order reasons determining action or inaction. This would be out of respect for the fact that the nurse does not work in isolation but as a member of a multidisciplinary team: a team with members who may be thought to be sincere in their commitment to patient care, notwithstanding disagreement about how to interpret this.

It is over the kinds of examples which relate to example four that I think nurses find the issue of medical authority most in conflict with their sense of professional integrity. Trying to cope with the moral complexity of such matters and to assess whether an authoritative command is legitimate or not and what may be the consequences, both prudential and moral of obeying and disobeying, can create high levels of stress and distress. In the UK, our health care institutions seem currently unwilling to put mechanisms in place to facilitate the resolution of such difficulties.

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