Dear Mary

by Mary Annas

Dear Mary is a monthly feature in which readers can ask about any nursing care issue that concerns them. Answers will be supplied by Mary Annas or a consulting nurse, physician, lawyer, or ethicist where appropriate. Readers are also invited to comment on the answers.

Dear Mary,

The advice you gave the senior nursing student, "Sandy" from Minneapolis (Vol. 1, no. 1) as to how to deal with a serious problem she encountered in relation to her patient's safety is not sound.

You advise her to be more mindful of the feelings of the physician than for the safety of the patient. This is regrettable; this student was probably carrying out a behavior she was taught — and properly so; yet, she had no support system in that neither her instructor nor the nursing staff in the agency gave her any assistance or support in a difficult situation; she was completely on her own. No one validated for her that what she was doing was both appropriate and commendable. Your response to her was equivocal, and reflects pragmatic rather than principled considerations.

We all claim we wish to teach nursing students to practice ethically. There is a great deal of verbalization, and insufficient role modeling, reinforcement and support when our neophytes "stick their neck out" and take a courageous stand. Risk-taking, and other professional behaviors can not be internalized, sustained or enhanced under contradictory and adverse circumstances.

Shaké Ketefian, Ed.D., R.N., F.A.A.N.
Associate Professor of Nursing
New York University
New York, N.Y.

Dear Shaké:

I agree completely with you. What I meant to convey in my original response was that if the older physician is not accustomed to nurse assertiveness and is approached in an aggressive or awkward manner (neither of which Sandy did), he may respond in a way that is defensive and ultimately harmful to the patient. Of course patient safety is the primary responsibility of all nurses, students and graduates alike. Thank you for your letter.

Dear Mary:

I am a subscriber to your new publication and I really enjoy it and I am learning from it. Right now, I have a problem: "The use of investigational drugs to be administered by the R.N." At present our nursing policy states that RNs may not administer investigational drugs. We are willing to change the policy since our neighboring hospitals have policies that allow an RN to give PO, IM, or large volume IV drugs. The policy includes that a protocol must be followed, informed consent obtained by the M.D., medications labelled and dispensed by the pharmacy and previous permission given to the M.D. by a review committee of the institution.

I would like your opinion and a bibliography to help us reach a decision re RN administration of investigational drugs to the benefit of both the patient and the nurse.

Thank you in advance for any help.

Elizabeth Allen, R.N.
Associate Director of Nursing
Lydia E. Hall Hospital
Freeport, N.Y.

Dear Elizabeth:

I have referred your important question to a health law expert who specializes in drug law. I think we all need more information about this critical area of nursing practice.

Your question is complex, and the many issues raised in it will be dealt with in an article in the next issue of Nursing Law & Ethics. *The short answer, however, is that when a physician is* treating *a patient, he may lawfully prescribe and the nurse may lawfully administer a "new drug." He may lawfully prescribe for a different purpose and in a different dosage than that listed in the package insert. Congress has made it clear that the FDA may not restrict the practice of medicine by regulating individual doctor-patient treatment; and the labelling information on the drug may not preclude the physician from exercising his own independent medical judgment (which, if negligently arrived at, may give rise to a malpractice suit).*

If the physician is not treating the patient, but doing research *with a new drug, federal laws and regulations require that prior approval be obtained from an Institutional Review Board and that the FDA's investigational new drug procedures be complied with. In addition, New York law requires a researcher to obtain a license from the Department of Health before engaging in research with drugs.*[1] *A registered nurse may administer a drug for research purposes only if the requirements of the New York drug research laws are complied with;*[2] *and New York law incorporates all federal drug research laws and regulations.*[3] *A nurse who disregards this law risks not only a civil malpractice suit, but also criminal prosecution and a complaint for professional misconduct.*[4]

Because of the importance of federal and state drug research requirements, competent legal counsel should be consulted.

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References

1. Controlled Substances Act, N.Y. PUB. HEALTH LAW (McKinney) Art. 33, sec. 3324-25.
2. *Id.* at sec. 3304.
3. *Id.* at 3325.
4. *Id.* at 3304, and N.Y. EDUC. LAW (McKinney) Art. 130, sec. 6509, 6510; and Rules of the New York State Board of Regents Relating to Definitions of Unprofessional Conduct, Part 29.

Dear Mary,

I am a student nurse who recently had the experience of being a patient, during the birth of my son. My husband was with me during the labor and delivery and several hours afterwards. We had the baby in a hospital that has a well-advertised reputation for being "family-centered," and yet we felt that after we scratched the surface of support, very few of the nurses actually believed that what we were doing was right — especially twenty-four hour rooming in. Several nurses kept asking my husband, "Wouldn't you like to go home and rest?" and continually asked me if they couldn't take the baby to the nursery so I could "get some sleep." It seems to me that there are still strong tendencies on the part of maternity nurses to keep control of "their babies," and I would like to tell them for one that new parents need their support, not their condemnation to help make the birthing experience in hospitals a joyful and pleasant one that it should be.

Michelle
Boston, MA

Dear Michelle,

I hope your letter helps nurses who have not already changed their attitude to at least re-evaluate it. In a regular med-surg setting the nurse has single patients, and most families do not actually feel that they are an integral part of the patients' surgical or medical treatment.

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Autonomy *Continued*

practitioners, efforts to achieve primary nursing, and collegial decision-making patterns by nurses — illustrate significant efforts to seek more autonomy and accountability for nursing to benefit clients through new nursing roles and new organizational patterns of health care delivery.

Nurses have not argued that they should be the sole arbiters of the limits of autonomy in the nursing profession, but have involved other members of the health care team. For example, physicians are involved in joint practice commissions at the national and state levels. Through such mechanisms as the *A.N.A. Standards for Nursing Practice*, consumers are also invited to participate in establishing effective nursing care delivery systems.

The nursing profession is moving from an authoritarian model for the delivery of an essential social service to a more participatory and reciprocal model. If nursing is arguing that this *should* be the model, there are implications for nursing, other health professionals, and client education, which need to be addressed. Changes needed in organizational structure involve not only economic, legal and political aspects, but also the value assumptions of nurses and others. Those who value authoritarian, paternalistic structures are not likely to readily accept models which challenge the traditional and familiar power structures in health care.

Role and organizational changes in nursing which affect other health care sub-systems, and are related to autonomy and accountability, are examined in a recent article by Cohen, a policy analyst for the U.S. Department of Health, Education and Welfare.[4] Cohen's discussion of the new environment of health professionals can be viewed as a warning to nursing in terms of goals and priorities, and as a support for current endeavors to enhance client welfare through contemporary role development and changes in organizational authority patterns. He comments on the movement away from professional autonomy. Independent functions are a myth due to the growing interdependence and specialization of function among the professions involved in health care. These realities profoundly affect the autonomy and overall responsibility of any single profession. Autonomy is further eroded by the incremental expansion of duties and responsibilities in certain health disciplines — nursing is but an example. Health care is increasingly interdisciplinary in form and substance. Sharp boundaries no longer exist — the result is frustration and a challenge professionally, ethically, and legally to health professionals and recipients of care.

The struggle for control of nursing practice by the profession must be reconciled with the present realities in health care described by Cohen, the assessed needs of society, and significant nursing documents which call for cooperative efforts with other providers and consumers. One of these historical documents is the 1959 *NLN Patients' Bill of Rights* which emphasizes that good nursing requires cooperation between consumer and provider, a more collegial, cooperative approach which challenges the authoritarian norm.

Conclusion

More autonomy in nursing cannot be an end in itself but must be a means to enhance one's personal and professional integrity, assuring accountability to self and others, and improving patient services. It promotes a more participatory, cooperative model of health care. The traditional authoritarian method has failed to meet the requirements of those suffering from chronic illness and those who profess concern for disease prevention. The goal of more autonomy in nursing must be balanced with efforts to achieve what both providers and consumers determine is the common and individual "good" in health care. Nursing provides leadership to some extent in this effort, but it is certainly not the sole determiner of its own fate in a system where economic and legal factors, and rules and regulations, often are the significant determiners of professional practice.

Nursing must study and deal constructively with its own inner contradictions as to the goals of autonomy and cooperation. Which will take priority? The question of who is responsible to set limits for professional autonomy implies that there are individuals or groups who should do this for others. After looking at some dimensions of this question, it seems more productive to view both autonomy and accountability as necessary but not sufficient means to the end of responsible nursing care. Primary care nurse practitioners, primary nursing, and new collegial organizational structures, demonstrate this notion. They incorporate both autonomy and accountability in today's complex and ambiguous world of health care, and include the patient as an autonomous, responsible person. The creativity, maturity, accountability and values of nursing will be reflected in the bargaining, advocacy, negotiation and compromise with physicians, legislators, third party payers, and consumers as nurses seek more autonomy and accountability for nursing.

References

1. Lambertsen E, *The Changing Role of Nursing and its Regulation*, NURSING CLINICS OF NORTH AMERICA 9(3):395-402 (September 1974).
2. Ciske K, *Accountability – The Essence of Primary Nursing*, AMERICAN JOURNAL OF NURSING 79(5):891-94.
3. Maas, M, *Nurse Autonomy and Accountability in Organized Nursing Services*, NURSING FORUM 12(3): 237-59 (1973).
4. Cohen H, *Public Versus Private Interest in Assuring Professional Competence*, FAMILY AND COMMUNITY HEALTH 2(3): 79-85 (November 1979).

Dear Mary *Continued*

Maternity is different. The nurse has at least two patients; and some believe three. Client centered teaching should include all members of the family. If the father is unable to participate, the mother should be able to choose another person. I think part of the teaching must include offering the mother and father options that they themselves may not have considered, e.g., letting the baby rest in the nursery for awhile.

Many nurses still do call nursery babies their babies. It's easy for student nurses to pick up and use the phrase, "my baby," just as some still ask a patient, "how are we doing today?" This is harmless so long as it does not evidence a desire to take control away from the parents of the child. I believe that the nurses' responsibility is to teach *well* baby care and some aspects of parenting to new parents. But from the time the child is born, the parents are the ones who have ultimate responsibility and who should make all important decisions about their child (except, of course, in cases of child abuse or neglect). I also believe strongly in the importance of early bonding between both parents and the new baby. New babies need a lot of touching and talking to and I think in most instances this is best done by the parents.