The moral foundation of nursing

The authors argue that the moral predicament facing nurses is their not being free to be moral because they are deprived of the free exercise of moral agency. Two occurrences are needed for nurses to be free to be moral: (1) the emergence of a strong sense of professional autonomy for nurses and (2) a shift in the locus of accountability from other health care professionals to the patient. The direction urged is to view nursing ethics as reform ethics.

Roland R. Yarling, MA
Doctoral Candidate
The Divinity School
University of Illinois at Chicago

Beverly J. McElmurry, EdD
Professor
College of Nursing
University of Illinois at Chicago
Chicago, Illinois

THE MORAL FOUNDATION of nursing is crucial and determinative of the well-being of the profession. Professional ethics deals with matters that lie at the very core of a nurse's professional life.

Nursing ethics is discussed here in the context of nursing *practice.* The *conclusion* is presented first and is followed by supporting considerations. The conclusion, or proposition to be argued, is that *nurses are often not free to be moral.* A couple of qualifying statements are necessary to properly circumscribe this proposition. First, it is confined to those nurses who practice in hospitals. While it is true that important nursing activities take place in other settings,[1] the majority of all practicing nurses are found in hospitals. Second, the concept of freedom, as in "not free to be moral," is not a reference to transcendental freedom of the *will,* for freedom in this sense is a necessary condition of even being a moral agent and having moral problems. The reference is rather to free-

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dom of *action* in the sense that acts are free from unforced choice.

The idea that nurses are not free to be moral was first raised by Davis and Aroskar in *Ethical Dilemmas and Nursing Practice.*[2] In a bold and pioneering chapter, entitled "Professional Ethics and Institutional Constraints in Nursing Practice," they identify several organizational and social constraints in hospitals that impede the ethical practice of nursing. These constraints include the role and social position of the physician and the nurse in the bureaucratic hospital's social system, the role and power of the nursing leadership in the system, sexism, and paternalism. The crucial question as to the nurse and ethical dilemmas is, given these factors, *can the nurse be ethical?*[1(pp42-43)]

The problem of nurses' freedom to be moral was also addressed by Curtin.[3] Clearly, she wrestled with the same problem when she stated that "ethical problems arise from the usurpation of the legitimate authority of the nurse over *nursing* decisions regarding care. The major ethical dilemma in nursing is that nurses are not free to practice nursing."[3(pp22-23,25)]

Further specifying the proposition, the moral situation of hospital nurses finds expression in a variety of clinical, patient care problems common to hospital nursing. Among these are care of patients in pain, cardiopulmonary resuscitation, withholding or withdrawing of life-sustaining treatment, informed consent procedures, refusal of consent to treatment, use of placebos, harmful care by another practitioner, and professional control of information. These problems are the locus of frequently recurring institutional conflicts involving nurses. The constitutive elements or preexisting conditions of these conflicts are

- established standards of nursing care as determined by the profession;
- consequent commitment of the nurse to the autonomy and well-being of the patient;
- responsibility of the hospital for all patients who receive care under its auspices;
- nurse's knowledge of actual or potential harm to the patient;
- divergence of the interest of the patient from the interest of the hospital or one of its power structures;
- employee status of the nurse in relation to the hospital;
- physician power structure in the hospital;
- nurse's subcollegial relation to the physician; and
- vulnerability of the nurse to harmful action by the hospital as the employer.

These are the complex, preexisting conditions out of which conflicts arise around specific clinical issues. When these situations, with their potential for conflict, are translated into the perspective of nurses, they may be described in terms of the several obligations encompassed by the nursing role: to the patient, to the employer, to the physician, to the profession, to nursing administration, to the nurse as a moral being, etc.

The moral situation of nurses is most poignantly revealed when they perceive that the right to freedom and well-being of patients in their care and treatment is threatened or violated by a physician, another nurse, or some other health care provider for whom the hospital is responsi-

ble. In such instances, nurses experience conflict, with respect to their choice of action, between the prima facie right of the patient and the prima facie right of the hospital. The prima facie right of patients, as perceived by nurses, is to freedom and well-being with regard to treatment and care in the hospital; the prima facie right of the hospital, as perceived by the hospital in such situations, is usually the right to institutional maintenance, broadly construed, which is instrumental to its primary purpose of care for all its patients in general. This responsibility for and right to institutional maintenance for the sake of all patients served may be construed in such a way that it comes into conflict with the interest of particular patients or all patients in a particular way. This produces conflict for nurses because their role embodies obligations to both patients and the hospital.

At stake in this conflict, for nurses, is nothing less than the nurse-patient relationship. The nature of that relationship is fundamental to the nursing process and to the human quality of a patient's hospital experience. Furthermore, it is the necessary foundation for a nursing ethic. The conflict relative to this issue is acutely problematic for nurses because the hospital is usually able, as the employer, to force nurses to act in compliance with what it perceives to be in its interest. The threatened retaliation of a hospital against nurses, when they act or contemplate action on behalf of patients whose rights are in conflict with the interest of the hospital, generally causes a forced choice to refrain from such action.

Nurses then are not free to be moral in the sense of not being free from forced choice. They are not free to fulfill their moral obligation to the patient when the interest of the patient is in conflict with the interest of the hospital. They are not free to act apart from the risk of serious harm to their own well-being. They are forced to choose between patient interest and their own self-interest, between their commitment to the autonomy and well-being of the patient and the autonomy and well-being of their careers, between moral integrity and professional survival. The fundamental moral predicament of nurses is that they often are not free to be moral because they are deprived of the free exercise of moral agency.

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The moral predicament of nurses arises from their commitment to patients, and that commitment is grounded in nurses' status as moral agents. Were nurses simply the instrument of those around them, as they are often assumed to be, then they would have no moral problem and no sense of not being free. An incident demonstrating this point occurred a couple of years ago when the first author, two nurses, and a physician formed a panel for a freshman medical school class in medical ethics. Under discussion was the role of the nurse in disclosing information to terminal patients. The question was, if the physician of a terminal patient has ordered that no information regarding the patient's prog-

nosis be disclosed to the patient, and if the patient asks the nurse about the prognosis, what is the nurse's duty?

Every medical student who spoke in class that day held that the nurse had a moral duty to disclose and that the physician's order was unjustifiable. The physician on the panel, however, argued that the nurse had no such duty. One of the students asked, why not? The physician replied, "Because the nurse's relationship with the patient is different than the physician's. It does not require independent moral judgment by the nurse." That is to say, nurses have no duty to make autonomous moral judgments about what their relationships with patients require because their relationships with patients are different. They have no moral status. In this sample, the nurse-patient relationship—the moral foundation of nursing and of a nursing ethic—is negated and denied moral status.

HISTORICAL PERSPECTIVE

Having explicated this thesis, an examination of the historical perspective of the issue is in order. In its present form, the commitment of the nurse to the patient is a relatively recent phenomenon. This is not to say that there was ever a time when the nurse was not committed to the patient, but in earlier days that commitment was considerably diluted by the nurse's relationship to the hospital and to the physician. The following admonitions provide insight into how far removed current practicing nurses are from those pioneer nurses who established schools of nursing in the nineteenth century.

> Absolute and *unquestioning obedience* must be the foundation of the nurse's work, and to this end complete subordination of the individual to the work as a whole is as necessary for her as for the soldier.[4(pp96-97)] (Emphasis added.)
>
> Implicit, *unquestioning obedience* is one of the first lessons a probationer must learn, for this is a quality that will be expected from her in her professional capacity for all future use.[5(p57)] (Emphasis added.)

Even after the turn of the century, the theme continued.

> It is expected of all in training to do what they are told; no more, no less.[6(p452)]
>
> *Obedience* is the first law and the very cornerstone of good nursing. The first and most helpful criticism I ever received from a doctor was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out his orders.[7(p394)] (Emphasis added.)
>
> Loyalty to the physician is one of the duties demanded of every nurse, not solely because the physician is her superior officer, but chiefly because the confidence of the patient in his physician is one of the important elements in the management of his illness.[8(p25)]
>
> She [a nurse] has a duty of charity as a faithful servant to a master to protect the good name and reputation of the physician under whom she is working.[9(p149)]

These quotations convey a sense of the difference in the professional identity of early twentieth century nurses and their contemporary counterparts. For nurses to be free to be moral, two necessary, but not sufficient, occurrences must take place: (1) the emergence of a strong sense of professional autonomy and (2) a shift in the locus of accountability from the physician to the patient. The evolution of a professional identity and commitment, which illustrates

the above factors, began in nursing by the end of World War II. Perhaps the most symbolic evidence of the changes that were afoot is the American Nurses' Association's *Code for Nurses.*[10] While this code, like most professional codes, has probably had minimal impact on practice, it is a reasonably accurate register of the changes that were taking place.

The first version of the code was adopted in 1950,[10] and the fourth and most recent one was adopted in 1976.[11-14] In that 25-year period, each version progressively reflected two emergent factors—professional autonomy and shift in accountability.

Present-day ideology of nursing, emphasizing nursing commitment to patients and autonomy in the exercise of that commitment, is a very recent development in the history of nursing. Nevertheless, it has had a pervasive and far-reaching effect. For example, few nurses graduating from basic nursing education programs in the past ten years think they owe physicians anything other than professional excellence in practice. Even the staunchest members of the old guard have been reindoctrinated with the new ideology.

So pervasive is this new ideology that it is surprising it is not being carried out in practice. The reality is that the ideological revolution in education has been a revolution in theory only; it has not pervaded the domain of practice. Nurses are not able to actualize their commitment to patients in the practice setting when the freedom and well-being of the patient is in conflict with the interest of the hospital. "Oh no," you say, "that can't be. Student nurses today are taught that nursing requires patient advocacy, that patient care comes first." Yes, that is what they are taught verbally and overtly; but in a thousand nonverbal and covert ways, they are taught by clinical example the limits of that advocacy. They learn quickly, by observing others, how to interpret the verbal message in terms of "what nurses do" and "what nurses do not do." They learn that their commitment to patients must be carefully contained.

Graduates from basic nursing education programs are psychologically part of the health care subculture, even though they verbalize patient-centered ideology. The nonverbal socialization process in the practice context is as powerful and thorough as the verbal and ideological socialization in the education context. In its construction of a new identity for the neophyte professional, it ultimately prevails. Professional nurses are conceived in moral contradiction and born in compromise. There is a profound moral dissonance between nursing education and nursing practice. This discord extends to the core of professional identity and leaves nurses essentially morally unintegrated professionals who are not self-determining, moral agents.

There is persuasive evidence, some systematic and some anecdotal, that this is the case. First, Swider et al[15] reported on a classroom exercise that examined the priorities reflected in the decisions reported by students when presented a case depicting the ethical dilemma in nursing. The exercise dealt with a primary nurse who was aware that the hospital was covering up the death of a patient as a result of a tenfold overprescription of a drug used in chemotherapy. The students were 175 seniors in baccalaureate nursing programs in 16 midwestern colleges and universities. Working in groups of five each, the stu-

dents arrived at a course of action to deal with the dilemma. Categories for classifying responses were derived from the literature[16-18] in nursing ethics.

The categories used in content analysis of responses were (1) patient-centered responses, (2) physician-centered responses, and (3) bureaucratic-centered responses. The small groups of students made from 3 to 17 decisions trying to resolve the dilemma, with a mean number of 8 decisions per group. Of the 1,163 decisions, 9% were patient-centered, 19% were physician-centered, and 60% were bureaucratic centered. Selected characteristics of participants were examined for relationships to group responses. Group responses did not differ significantly according to education, clinical experience, previous experience with a similar dilemma, or RN status of group members. Students agreed on the first steps to take to resolve the dilemma, but failed to achieve a consensus on where the nurse's responsibility ended.

CASE STUDIES

Although the literature has oblique references to the conflict over the problem of nurse ethics, Stenberg says, "These cases are rarely documented in the nursing literature, due in part to a reluctance to confront or to publicize conflict within the profession or those between nursing and an agency.[19(p11)] One of the few specific cases in the literature is presented by Donnelly et al.[20] It concerns the firing of a director of nursing over conflicts concerning the right of nurses to practice nursing. Many nurses in the agency protested the firing on the basis that "Both medicine and administration had repeatedly interfered in the rights to practice professional nursing."[20(p28)]

In the final paragraph, they observe: "The price of speaking out can be a difficult one to pay. Some of those who resigned have been discredited in references. Others have been subjected to humiliating . . . job interviews. . . . the rewards for prudence are great."[20(p28)]

Donnelly, Mengel, and King resigned in protest, and later collaborated on this article, which explains why it was written and why many others like it are not.

Another case illustrating the "hospitalonian captivity" of nursing was discussed by McGuire.[21] She related a situation in which a patient, in her professional judgment, was being medically mismanaged and subsequently died. Her lament was that she did not insist on a consultation that might have saved the patient's life. She says, "Never again will I back down before a tradition-encrusted system or an ego-driven physician when a patient's well-being or dignity is at stake."[21(p56)]

A third case reported involved a physician who ordered a nurse not to disclose to a terminal patient her prognosis, even though the patient had asked the nurse direct questions.[22] The final lines in that case presentation indicate the conflict as the nurse followed the physician's order:

> 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.[22(p28)]

It is difficult to imagine a more insidious violation of the fiduciary nature of the

nurse-patient relationship than that in which this nurse found herself.

A fourth case, related by Curtin,[3] involved a young nurse having repeated confrontations with a resident over medication orders which the nurse repeatedly observed to be inappropriate and dangerous. Finally, a patient died from respiratory failure, apparently from an overdose of medication causing respiratory depression. The nurse's efforts to discover what had actually happened were systematically frustrated. The next day as she sat alone at a lunch table, she was joined by the chiefs of pharmacy, medicine, and staff; the director of nursing; and the hospital administrator. "To say the least, these were not the people with whom she ordinarily ate lunch. It seemed she was upset about something, they said. It seemed that the pressures of working on acute medicine were too much for her and that she needed to be transferred to a less demanding ward where she could recuperate from the rigors of acute medicine."[2(p21)] She was immediately transferred and subsequently harassed until she finally resigned. A hospital sometimes can be very persuasive.

There are also a couple of cases documented by Creighton[23] in the legal context of whistle-blowing. A staff nurse refused to carry out the following order: "Give the patient 200 mg of Demerol [meperidine hydrochloride] and 25 mg of reserpine, IV, and discharge her immediately." When the nursing supervisor and the director of nursing supported the staff nurse's refusal, the physician on the hospital board said he would have all three of them fired. Though not relating the denouement of that situation, Creighton, in commenting on it, referred to the significant legal case of *Rafferty vs. Philadelphia Psychiatric Center*. Mrs. Rafferty was a psychiatric nurse who was fired after her criticism of the medical and patient care at the center appeared in the newspaper. "During the time of her employment she had repeatedly tried to secure improvements by reports made through hospital channels. . . . While the nurse's comments did cause controversy, the court said: 'Mrs. Rafferty was engaging in precisely the sort of free and vigorous expression that the First Amendment was designed to protect.' "[23(p11)] And Creighton, commenting on the general situation, said, "The many, many tough situations in which the consciences of nurses ache and where nurses writhe in frustration over wrongs in patient care that they cannot at the moment change, set the stage for more whistle-blowing by nurses."[23(p57)]

In addition to these published cases, there are other kinds of anecdotal evidence. In teaching ethics to nursing students, nursing instructors have numerous conversations with them about such matters. Even older nurses volunteer stories about ethics from early in their careers about patients who suffered serious injury or harm, which they thought might have been prevented if they had acted more aggressively. They are stories in which the nurses felt helpless and painfully compromised. Why do nurses tell these stories? Because they represent the symbolic, socializing events through which their moral predicament was revealed to them in its full-blown dimensions. Although largely repressed, these are the experiences around which young nurses formulate their professional identity, however fractured that image may be.

In this same vein, the president of a state nursing association tells of receiving calls in the middle of the night, not just once or twice, but several times, from nurses who were too frightened to tell their names. They wanted to tell her a story about some experience that was wrenching their souls, but about which they felt either too powerless or too fearful to do anything. The pathos and tragedy of nurses whose moral instincts have been so repressed that they are divided within themselves is a concern that must eventually be addressed.

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PRESENT-DAY REALITIES

Returning to the original proposition, how can it be said that nurses are not free to fulfill their moral obligation to patients? They can do whatever they choose to do. That is true in a sense. They are in some marginal capacity free, free at least to be heroic. And insofar as they are in some limited sense free, they are also in some limited sense culpable, for the risk attached to an action does not completely cancel the obligation to perform the action. If it did, nurses would have no moral problems, but unfortunately they do.

There is also a real sense in which nurses are not free. They are not free in the same sense that a victim is not free when a robber says, "Your money or your life." The victim can make a choice here, but one could not say the individual is free. The risks involved when nurses choose to act on behalf of patients whose rights are in conflict with the interest of the hospital are grave indeed. It is an indubitable fact for those who know the subculture of the health care professions and the power structures of hospitals that nurses who openly challenge established authority structures or powerful physicians in a hospital bureaucracy most often put their jobs, their economic welfare, and their professional careers on the line, even if they are acting on behalf of the patient and have strong justification for doing so.

In conflict over patient care situations, nurses often have the moral instinct founded on conscience, but will seldom act on their conscience when to do so is to act against the interests of a power structure that controls their professional and economic destiny. The average nurse is often expected to be a humble servant one moment and a heroic protagonist the next; it is not likely to happen. Nurses are confronted with situations that threaten to exact a price the average person is unwilling to pay. While nurses cannot be completely exonerated in this situation, their failure to make heroic sacrifices for patients is eminently understandable. While highly principled, heroic action is to be praised, it is also seldom to be found. The reason for this is not that nurses, as a group, lack principles. It is that they, like most ordinary mortals, are not capable of heroic action on a routine basis. When the institutional context of nursing practice is

such that the commitment of nurses to patients embroils them in conflicts with powerful interests within the institution that employs them, it is unrealistic to expect that the commitment will be routinely honored. While it is common to offer praise for highly principled, heroic action in the face of great risk, it should not be expected as a routine attribute of institutional life. To do so is to fail to understand the institutional conditions necessary to foster consistently responsible moral action.

INSTITUTIONAL RESPONSIBILITY

It should be clear at this point in the analysis that the improbability of moral actions by the individual nurse under extremely adverse circumstances is not to be construed primarily as an indictment of the moral character of nurses (although their responsibility is inescapable). Rather, the principal indictment is intended for those institutional structures that systematically create formidable obstacles to responsible action. It must be clear to all that there is grave institutional culpability in a situation where the institutional disincentives to morally responsible action are so persuasive that the probability of moral action by the average person is rendered minimal. When social institutions are so construed that they systematically create overwhelming disincentives to responsible action, then they must be held responsible for the suppression of the moral impulse in everyday life. In a word, nurses are not free to be moral because they are deprived of moral agency by the repressive character of the hospitals in which they practice.

NURSING ETHIC AS A SOCIAL ETHIC

The principal conclusion that can be drawn from the foregoing analysis is that a responsible nursing ethic must be a social ethic. That is, if the fundamental moral problem of nursing is a consequence of the structure and policies of the social institution in which nursing is, for the most part, practiced, then any ethic that seeks to address this problem must seek reform of the policies and structures of that institution. An ethic that is concerned with structures and policies of social institutions is a social ethic. Hence, a nursing ethic must be first and foremost a social ethic. It must be one that seeks to free nursing *practice* from its "hospitalonian captivity," in the same way that the 1965 ANA resolution[24] on nursing education sought to free nursing *education* from that captivity. Ashley,[25] in making the same point, perceived the hospital as a demonic force in the history of nursing in this country. What is required from a moral perspective is a nursing ethic that will seek to free nursing from the hegemony of the hospital as a morally culpable social institution vis-à-vis its stance toward nursing.

GENERAL ALTERNATIVES

Precisely what policies and what structures are to be preferred in order to effect this liberation is not clear. It is a matter that

will require extensive and ongoing deliberation in the councils of the profession. However, the general alternatives are clear. Either nursing must acquire sufficient power within the hospital, relative to medicine and administration, to create a balance of power in the control of the practice, or it must terminate its employee status with the hospital, move outside the hospital, and serve hospital patients from the vantage point of some new nursing-controlled organization. The most effective alternative will emerge in the years to come. The concern here is not so much the instruments and technologies of this liberation as the credibility of this general analysis of nursing's moral situation and the viability of a nursing ethic, which is primarily a social ethic.

The suggestion that a nursing ethic should be a special ethic interested in social reform, that is, the reform of one of our major social institutions—the hospital—is characterized by both discontinuity and continuity. Nursing ethics as reform ethics represents discontinuity in at least two respects. First, the bioethics tradition in general, including nursing ethics and medical ethics, has been staunchly nonreformist. In a word, medical ethicists have explicitly disclaimed any interest in reform. The second point of discontinuity derives from the traditionally apolitical posture of the nursing profession itself. The rank and file has always been more personal than political, more concerned with serving individuals than with reforming institutions. This propensity is natural to a caring profession, but it is inadequate as a professional style when social and political forces increasingly determine the context and conditions of practice. The beginnings of change in this regard appear to be emerging where nurses have formed political action groups and have established Washington, DC-based lobbies. However, the rank and file of the profession remains predominantly apolitical.

Despite these discontinuities, there is a significant precedent within the profession for viewing nursing ethics as reform ethics. This precedent resides in an obscure and neglected sector of the nursing tradition, the social reformers. Even though the nursing profession has historically been apolitical, there is a slender but distinct thread of social reform in the tradition. Such individuals would constitute an excellent resource for the reformation of nursing ethics. If nursing ethics is to become more than a footnote on medical ethics, and if the profession is to put into practice the values that it affirms in its professional ideology and code, then the social reform tradition and its major prophets must be enshrined in the memory of the profession, discussed in the classrooms of professional education, and honored in the convocations of the profession. Nursing has not always honored its prophets. The profession should draw upon the spirits of such reformers as Mary Adelaide Nutting, Lavinia Dock, and Annie Goodrich, not to mention Florence Nightingale, in order to translate its ethical commitments to patients into carefully designed strategies for institutional reform.

Unless nursing, through the reform of the institution in which the majority of its members practice, acquires a balance of controlling power in that institution or creates new structures for the organization

of practice, it cannot effectively implement standards of care for its own practice. If it cannot realize reform it will compromise the integrity of the nurse-patient relationship, which is the moral foundation of nursing, and it will have lost its status as a profession. Furthermore, the public will have lost its most valuable ally within the health care system. The one action that would most improve the quality of health care in this society is simple and direct: Set the nurses free, set the nurses free.

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