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Establishing Limits to Professional Autonomy: Whose Responsibility?

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The social phenomenon known as professional nursing is kaleidoscopic. Nursing is embedded in an intricate network of relationships at all levels. This precludes any simple answer to the question of responsibility in setting limits to professional autonomy. It is useful to examine some of the pieces that one puts into one's kaleidoscope to look at the question. Asking any question which involves multiple relationships risks finding several possible answers which then require significant decisions and choices having far-reaching implications for individuals and groups. "Solutions" often challenge tenaciously held assumptions and values: this question is no different.

Nightingale, the founder of modern nursing, visualized the professional nurse as acquiring knowledge and developing character, both essential for carrying out a significant social service. These characteristics are also related to autonomy. A century ago, nursing was viewed as subservient to medical care, a view *not* held by Nightingale. In 1932, Goodrich spoke of the nursing profession as intrinsically ethical and an essential factor of the social order. She described the nurse as a public servant and viewed nursing as under the direction of doctors. The views of these two nursing leaders in different eras reflect the intra-disciplinary conflict which still exists.

The struggle for increasing autonomy is an on-going challenge as more nurses seek to develop co-worker and collegial relationships with physicians and other health workers. Varying definitions of nursing and the paradoxical strands of obedience, consumerism, and professionalism make unclear what nurses should be autonomous about and for what purpose autonomy is sought. Is it for a self-seeking end as it sometimes appears, for the general goal of improved service to clients, or an amalgam of the two?

In reflecting where responsibility should lie as we seek to define the limits of nursing autonomy, a dangerous assumption is often made; that every nurse has the same educational background, skills and talents. Talking to an adult nurse practitioner in a clinic, a staff nurse in an ICU, a community health nurse, and a nurse psychotherapist evidences the variety of backgrounds nurses come from. According to Lambertsen, the registered nurse group can be divided into two sub-groups: those who are prepared to function within existing structures or defined patterns of practice, and those prepared to function within unstructured or ambiguous patterns of practice (commonly, the nurse practitioner).[1] Degree of risk, dimensions of control affected by the presence or absence of a physician, and the nature of clinical judgment required, are aspects which must be considered in looking at the autonomy of decision-making in these two sub-groups. The incorrect assumption that registered nurses represent a homogeneous body of similar talents impedes understanding of the potential scope of nursing's contribution legally, philosophically, and practically.

Autonomy and Accountability: The Same Coin

Accountability and autonomy are opposite sides of the same coin: one can hardly be accountable professionally if one is simply a handmaiden to someone else. Autonomy has to do with the right of self-determination, governance without outside control, and the capability of existing independently. Independence places some immediate limitations on autonomy of any group of health professionals since health care often requires the technical expertise of several disciplines. The concept of professional autonomy also requires that practitioners be self-regulating and have control over their own functions in the employment setting. Nurses are confronted daily with the reality that others are (or consider themselves to be) in control of nursing.

Accountability has to do with responsibility and answerability to the patient or client for one's actions. The accountable individual is prepared to explain and to accept the consequences

(Continued on page 2)

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Contents

Establishing Limits to Professional Autonomy: Whose Responsibility?
by Mila Ann Aroskar 1

Health Law Notes: Nurses and the Death Penalty
by George J. Annas 3

Ethical Dilemmas: Reporting Incompetent Colleagues II: "Will I Be Sued for Defamation?"
by Jane Greenlaw 5

DearMary 4
Reviews 7
Medicolegal Reference Shelf .. 7

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