NURSES’ VOICES: POLICY, PRACTICE AND ETHICS

Mila A Aroskar, D Gay Moldow and Charles M Good

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This article deals with nurses’ ethical concerns raised by the consequences of changes in governmental and institutional policies on nursing practice and patient care. The aims of this project were to explore perspectives of registered nurses who provide or manage direct patient care on policies that affect nursing and patient care, and to provide input to policy makers for the development of more patient-centred policies. Four focus groups were conducted with a total of 36 registered nurse participants. The project team identified major themes that emerged in the analysis of transcripts of the focus group discussions. The four major themes were: effects of policy focused on cost containment, effects on quality of care, effects on patient education and access to needed services, and effects on nurses and nursing. The participants identified primarily negative effects of changes in national health policy and legislation that influence institutional policies on patient care and nursing practice. The effects of identified policy changes raised concerns about meeting nurses’ ethical obligations to patients and families. Participants specified key points for consideration by legislators and other policy makers. They viewed nurses who are involved in direct patient care as a critical resource for legislators and other policy makers in the development of public and institutional policies that affect nursing and patient care.

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Nurse who provides direct patient care

Introduction

Health policy development and implementation continue to challenge the ethics and values of individual nurses and the nursing profession. A burgeoning literature urges nurses to participate in politics and policy development in order to develop health policy that is focused on patient needs.1,2 Yet little research has been conducted on nurses and health policy3 or on how nurses perceive the effects of policy on their ethical obligations. This article provides a brief overview of a project that explored...
nurses’ concerns for the effects of evolving health policy on patient care and nursing practice, with a focus on ethical concerns related to these policy effects.

The aims of this project were to explore the perspectives of nurses who provide or manage direct patient care on health policy development and implementation that influence patient care and nursing practice, and to provide input for action by policy makers through the use of focus group conversations. These aims were supported by the reality that nurses, as key health professionals, are crucial decision makers in the allocation of human resources, equipment and supplies, bed space and time in the delivery of patient care. Policy and practice issues were discussed in the broad context of professional ethics and values, a cost containment environment in health care, and quality of care issues.

Ethical challenges in policy development and implementation are seldom discussed explicitly in general nursing or health policy literature. A similar situation exists in the nursing ethics literature that focuses on ethical issues and dilemmas in patient care. Although information about policies may be provided, issues of policy development and implementation are seldom addressed, even though they often create ethical problems for nurses on the front lines of patient care. One example from the nursing literature is a national survey of 7000 nurses’ views on the effects of health care reform on health care itself and nursing practice in 1994 that did not explicitly address ethical concerns.

A few US studies of nurses’ perspectives on ethical and policy issues concerning the allocation of resources focused primarily on nursing service administrators in hospitals. One study identified major ethical concerns for nurse executives in the allocation of scarce resources and the nursing organizations that could assume major responsibility for formulating policies to address these concerns. The major ethical concern in this study was using staff and staffing patterns that were inappropriate to the severity of patients’ illness. This was not a new ethical concern for nurse administrators. Other pressing concerns, in addition to making resource allocation decisions, included prolonging life with costly technology without valid moral justification, inadequate resources to care for nonreimbursed indigent populations, health care decisions driven by reimbursement programmes, and ineffective use of hospital beds. Study participants identified the American Nurses Association (ANA) and the American Organization of Nurse Executives as the professional organizations that should assume major responsibilities for developing policies that address the ethical issues related to the allocation of scarce resources. Another study identified the three most pressing ethical concerns for master’s students in nursing service administration. They were: delivery of health care, safe staffing patterns, and appropriation of financial resources for delivery of health care. These policy related findings are similar to those noted in surveys conducted by the ANA Center for Ethics and Human Rights at the 1994 and 1996 ANA Conventions.

A study at a Canadian teaching hospital explored the ethical issues in resource allocation and utilization decisions faced by clinicians with management responsibilities, including nurses. Ethical issues included fairness, concerns with preventing harm, respect for consumer/patient choice, balancing the needs of different groups of patients, conflict between financial incentives and patient needs, and professional autonomy.

These studies sampled primarily the perspectives of nurse administrators and managers from the USA and Canada on ethical issues in resource allocation
and related concerns, such as the use of staffing patterns inappropriate to patient needs and reimbursement issues. At the time this project was conducted in 2000, these policy related issues and their consequences for the daily care of patients continued to trouble the nurse participants in this project who provided or managed direct patient care in acute, long-term, and community based health care settings.

**Method**

**Participants and procedures**

The University of Minnesota Institutional Review Board determined this project to be exempt from review under federal guidelines. Focus groups composed of practicing registered nurses (RNs) were used as the most appropriate way to explore grass-roots nursing perspectives on health policy and its effects on patient care and nursing practice. According to Krueger, the use of focus groups is appropriate in qualitative research when little or nothing is known about an area.

The project participants were 36 practicing RNs with a mean age of 51 years. The majority were self-selected members of the Minnesota Nurses Association who responded to invitations issued at Association and hospital ethics committee meetings. Thirty-three participants (92%) were providing or managing direct patient care in a variety of clinical settings at the time of the study. One-third were in acute care; others worked in long-term care, emergency or urgent care settings, and community settings such as home care and school nursing. Labour and delivery, obstetrics and psychiatry were also represented. Several participants held positions that combined responsibilities in direct care and management or education, which is reflective of the average age of the participants. Five of the RNs held primarily administrative positions. One participant was an educator who also worked in acute care nursing and one was in policy work; all had extensive bedside nursing experience. The highest level of participants’ nursing education ranged from the diploma to the doctorate, with 64% having a baccalaureate degree or higher in nursing and 33% holding degrees in other fields such as philosophy, psychology, public administration and education. Thirty-one per cent had taken an ethics course and 22% had taken a policy course. The participants signed consent forms at the beginning of each focus group session and received an honorarium after the focus groups were completed.

A moderator guide for conducting the focus groups was developed by the project team, which was composed of the project leader (who was a nurse ethicist) and two project associates (a nurse social worker and a health policy expert). The guide consisted of three major areas for discussion developed by the team, with opportunities at the close of the formal discussions for any additional comments. Discussion topics for this project evolved from a group of community based leaders in Minnesota, which was convened in 1999 to develop and hold town hall forums to consider health policy issues such as priorities in health care, costs of health care, appropriate use of health care technologies, and reimbursement for those technologies. The group was composed of individuals from law, medicine, manual labour, business, education, politics, and health care administration. The absence of nursing representation in this group provided the impetus for the current project, even though nurses may have participated later in the town hall forums. Discussion topics for the focus groups were:
identification of government policies and legal mandates that influenced policies and practices in participants’ employing institutions; (2) policies and policy changes under the rubric of managed care or health care reform that directly affected the nursing care of patients and the role of nurses; and (3) identification of key considerations that nurses thought legislators and other policy makers should include in the development of more patient-centred health policies.

The nurse project leader led the discussions in all four focus groups during May and June of 2000. Each group was composed of 7–10 participants from acute, long-term and community based settings, plus the two project associates who took notes and provided a summary of each session. Approximately half an hour was allotted for each topic in the two-hour discussion period. Transcriptions of the focus group discussions were used for content analysis. The computer software program, ATLAS-ti, was used to organize the transcription data initially. Project members met for lengthy sessions over a four-month period after independent reviews of the data, to reach consensus on major findings and emerging themes. Four major themes were readily identified from the first two topics: effects of policy focused on cost containment, effects on quality of care, effects on patient education and access to services, and effects on nurses and nursing. The third topic area, information for policy makers, was treated as a discrete item.

Limitations

Focus group interviews have several limitations, as do all techniques for gathering information, including less control by the moderator, differences between groups, and challenges in analysis of data. Moderator control was enhanced in this project by the use of identified ground rules for focus group participation, the use of identified topics to focus discussion, and a stated period of approximately half an hour for each topic within each two-hour discussion. Each group was composed of participants from acute, long-term, and community based care settings.

The project findings are limited to focus groups composed of self-selected female RNs and conducted in an urban area. Some participants served on ethics committees of institutions or professional nursing organizations, which may have accounted for the introduction and discussion of ethical concerns. All focus groups identified the lack of perspectives from younger nurses and new graduates as a serious limitation, given the participants’ mean age of 51 years and the more than 20 years of nursing experience for 24 participants. All groups recommended that this project should also be conducted with groups of younger nurses and new graduates for comparative purposes. They acknowledged that younger nurses are generally more assertive than the participants in this project.

Findings and discussion

The findings on ethical issues and concerns raised by policy consequences on patient care and nursing practice are reported for the four focus groups as a whole owing to the similarity in composition and small size of each group.

Participants readily identified policies and policy changes at national and institutional levels that affected their daily care of patients and raised ethical
concerns. They dated major changes in policy and practice from the introduction of diagnostic related groups for the reimbursement of patient care in hospitals in the 1980s and the advent of managed care. They readily acknowledged flaws and challenges to nurses’ ethical obligations in the old fee-for-service arrangements for financing health care. Medicare, Medicaid, managed care policies and changing regulations were continually reaffirmed as current forces in health care financing and clinical care delivery. Four main themes were identified as relevant to nurses’ perspectives on policy consequences for patient care and nursing practice that raised ethical concerns: effects of federal and institutional policies that focused on cost containment; effects on quality of care for patients and families; effects on patient education and access to needed services; and effects on nurses and nursing practice. Examples of comments from project participants are provided for each theme. The four themes also provided the context for items that participants identified for action by policy makers.

**Theme 1: Effects of policy focused on cost containment**

Participants focused primarily on national legislation and regulations that influenced institutional policy and cost containment efforts in their own practice settings. They stated that the focus on cost containment in patient care settings has been dramatic, almost to the exclusion of considering consequences for patients, families and nursing staff. Several viewed their inability to meet patient needs as a major ethical concern given their personal and professional ethical obligations to avoid harm to patients and provide care irrespective of economic status and other factors.

Participants who worked in acute care indicated that nurses now often do what is paid for rather than assessing patient needs and developing a plan to meet them. This reality was perceived as a threat to the nurse’s professional commitments, ethical obligations and personal integrity. Long-term care nurses focused on the effects of changes in Medicare and Medicaid regulations for the care of patients in both nursing homes and transitional care settings in a managed care era. One stated that ‘Medicare rules really impact what happens [in patient care] . . . Medicare calls the shots. What Medicare says is what everybody else does.’ These rules and regulations dictate care settings that may or may not be appropriate for individual patients. Another noted that nurse practitioners in nursing homes are monitored for their number of hospital admissions in a context of cost containment rather than patient need with ‘additional pressures to not order specialty beds, specialty equipment, antibiotics, and certain medications.’

Emergency room nurses focused on the influence of the Emergency Medical Treatment and Labor Act, also known as the ‘patient anti-dumping law’. It requires all individuals presenting in the emergency room to be assessed for the presence of an urgent medical condition. This aspect of the Act led to the inability to refer some patients to more appropriate care settings, such as an adjacent primary care centre, without the costly use of emergency room resources for an initial assessment. Participants were concerned about issues of justice and fairness in what they considered to be inappropriate use of limited resources.

Major concerns about the effect of cost containment policies and their implementation on nursing and patient care influenced the discussions in all four focus groups as
the bottom-line issue. Conflict between financial interests, incentives and patient needs is not limited to the USA. Clinician managers in a Canadian teaching hospital, including nurses, experienced similar conflicts in their resource allocation decisions.\textsuperscript{11}

**Theme 2: Effects on quality of care**

Participants identified several examples of changes in policy and practice that affect quality of patient care. Institutional policies that lead to downsizing of RN staff and the use of less expensive unlicensed assistive personnel, almost interchangeably with RNs, have created situations in which ‘nobody knows what a nurse is any more…our boundaries have become so blurred with theirs [unlicensed assistive personnel].’ Instances were cited of patient care practices by unlicensed personnel, such as patient care assistants and certified nursing assistants, which put patient health and safety in jeopardy. For example, a seriously ill patient had to educate a nursing assistant about a safe level of activity. The assistant insisted the patient do something that an RN had already told the patient was unsafe. According to participants, unlicensed assistive personnel do not have adequate training to provide patient care in situations that require comprehensive nursing assessment and decision making. One participant commented that sometimes charge nurses who are responsible for co-ordinating patient care are left out of communication loops with physicians and other caregivers because of confusion about who is providing nursing care for patients. This lack of clarity contributed to staff frustration and compromised patient care. Another participant cited an instance in which a patient almost died because the RN was not in the communication loop.

One participant described the unrealistic expectation of assigning responsibility to one nurse for three or more patients receiving chemotherapy, which made it impossible to provide holistic care for patients who were desperately ill and often frightened. For her, this was a major ethical dilemma. The shortage of RN staff and adequately trained care assistants to meet patient needs was also cited as a major concern in home care and other community based care settings. Not surprisingly, these concerns about inappropriate staffing levels to meet patient needs based on the severity of patients’ illness were expressed as ethical concerns by participants from most care settings. Such realities created major challenges to nurses’ ethical obligations to avoid or prevent harm to patients. These concerns were similar to those of practicing nurse administrators and master’s level administration students more than a decade earlier.\textsuperscript{6,7} One participant indicated on a positive note that the study of severity of illness in her hospital did lead to more adequate staffing.

Several participants expressed profound concern for the emphasis on the technical aspects of nursing care and the loss of what many termed an ‘ethic of care’. One said, ‘I became a nurse to care for people . . . one of the things that’s been most frustrating, if you look at service and distribution of resources including allocation of nurses as resources, that ethic of care is just going, it isn’t there.’ Examples from acute care settings included the lack of time to provide comfort measures such as back rubs for patients, lack of time for meaningful nurse–patient communication, and lack of adequate nursing support for dying patients and their loved ones. The participants viewed comfort care measures and support for patients and families as critical aspects of nursing care that are reflective of professional ethics and values.\textsuperscript{13,14} A 1994 national survey of 6000 nurses’ views on the effects of health care reform found that keeping
‘care’ in nursing and patient care was viewed as the biggest challenge in the current health care climate.\textsuperscript{5}

One participant noted that patients and families sometimes commented on how much they appreciated the positive effects on care when nurses and physicians work together as a team. This observation reaffirmed the critical importance of nurses and physicians working together in both clinical care and related policy activities, which has long been an ethical obligation found in the ANA codes of ethics.\textsuperscript{13,14}

**Theme 3: Effects on patient education and access to needed services**

Participants emphasized increased needs for patient and family education on how to deal with the complexities of today’s health care system and how to meet institutional expectations that patients and families should take more responsibility to provide care themselves. Inpatient nurses cited little or no time to plan for continuity of care, discharge planning and the necessary education required to meet continuing care needs after discharge. Communication between hospitals and long-term care facilities was also cited as missing or inadequate at discharge from hospital to nursing home or vice versa. Inadequate discharge planning and education for patients and families often left families feeling abandoned and ill-prepared to provide care after discharge. One participant commented: ‘We expect families to do a lot, but we don’t give them any help to do it.’ This led to a ‘revolving door’ effect on some patients who had to return to an inpatient setting or emergency room almost immediately after discharge from acute care, a clear negation of nurses’ ethical obligations to provide respectful care and prevent harm. These consequences could, most likely, have been prevented with thorough discharge planning and better education.

Participants generally viewed the national Patient Self-Determination Act positively because it requires providers to inform adult patients about their rights to accept or refuse treatment and the right to execute an advance directive for care in the event that the patient becomes unable to participate in decision making. However, some participants expressed reservations about this requirement owing to a lack of adequate education for individuals to prepare advance directives. Ideally, these directives for decision making for end-of-life care include such ethical and professional values as respect for patient and family wishes, and provision of appropriate patient care and pain management.

Home care patients who insist on supervising their own care when they lack the necessary education to do so were another facet of the inadequate patient education theme. Patient ‘misuse’ of the emergency room was identified by some focus group respondents as a major issue owing to changing patient populations in inner city areas, inadequate education about health, and lack of access to clinics and other sources of care in the inner city. All participants expressed frustration with the lack of time available to establish an effective relationship with patients and families in order to provide assistance and education for negotiating today’s complex health care systems, another element of nurses’ professional and ethical obligations as patient advocates.
Theme 4: Effects on nurses and nursing

Policy changes and administrative practices were cited as a source of decreased satisfaction of professional nurses, with the recruitment and retention of nursing staff as a major concern in all care settings. One participant stated that the ‘structure of delivery of care has really changed nursing. It didn’t necessarily have to be in a negative way, but it’s turned out to be negative … support structures are not in place for primary nursing or team nursing. There is a huge turnover of nursing staff.’ Acute and long-term care settings were especially noted for RN shortages and constant staff turnover. Long-term care, with its changing population of sicker patients, was cited as ‘the last place that people want to work … they get paid the least, they have the poorest package of benefits.’ Another participant cited workplace incidents in which RNs who expressed their concerns about patient care were unable effectively to advocate for their patients because their voices were not heard and they believed that they had no effective recourse.

Nursing was generally viewed by the participants as absent from the process of patient care policy development and interpretation. Consequently, there was little or no input from nurses who have daily experience with the effects of policies on patients, families and nurses. Nursing’s absence was especially significant for the participants because they thought that the interpretation and implementation of often conflicting patient care policies created problems for nurses, patients and their families. Institutional and administrative practices often negated nurses’ ethical obligations to work with others to meet patient needs through participation in policy work. The participants thought that nursing’s critical contributions to patient care were often not recognized or valued. The majority expressed concern that nurses increasingly have little or no control over their practice, which leads to feelings of oppression and moral distress or to leaving nursing altogether. One cited as particularly problematic the fact that, in some institutions, non-nurses have authority to make decisions regarding nurse staffing and nursing policy.

A positive consequence of administrative efforts to change policy without nursing input was noted in a maternity care setting. Staff nurses flooded the Chief Executive Officer with letters when administrators attempted to reduce nursing staff. Consequently, RN staff numbers were not cut. Ongoing task forces, composed of nurses and physicians, were created to have a more proactive clinical voice in proposed policy changes. A few other participants had similar positive experiences with multi-disciplinary task forces. Such mechanisms support nurses in carrying out their ethical obligations to work with others to meet patient needs and to improve health care environments through individual and collective action, and demonstrate respect for nurses’ contributions to meeting patient needs and goals for care.

All groups verbalized fears for the near and distant future of the nursing profession. These fears related to the continuing nursing shortage, downsizing of nursing staff, ageing of the nursing workforce, failure to recruit a new generation of nurses in sufficient numbers, failure to retain experienced nurses currently in practice, shrivelling of nursing’s traditional ethic of care, and threats to nurses’ professional integrity. Although some participants questioned whether they would recommend nursing as a career under current nursing practice conditions, no nurse expressed regret for her choice of career.
In summary, the consequences of ongoing changes in national health policy and legislation that determines institutional policies raised ethical concerns for nurses who provide direct patient care as they impact patient care policies and nursing practice environments. Many participants, however, said that they struggled to provide care reflective of ethical and professional values that included education and advocacy to meet the needs of patients and families, even though time for patient education and easy access to services are severely limited in today’s health care institutions where the containment of costs was viewed by participants as the major goal.

**Key information points for action by public policy makers**

After discussion of the first two major topic areas concerned with the consequences of evolving public and institutional policies on nursing and patient care, project participants were asked to identify information about patient care and the nursing profession that would be helpful to legislators and other policy makers for action in the development and implementation of health policy. These points were based on their daily experiences of the effects of policies and policy implementation on nursing and patient care and additional thoughts about what would be helpful in improvement of personal health, health of populations, and the health care system. Examples are given below, which are not presented in order of priority except for the first item:

- Involve nurses who provide direct patient care in health policy decisions;
- Give attention to the long-term care crisis;
- Pay attention to patients’ rights in and to health care;
- Consider quality of life in policy development, including adequate pain management;
- Deal with policy-related issues of end-of-life care with a focus on appropriate care;
- Achieve universal and easy access to health care services and education;
- Develop advocates to assist patients and families to navigate the health care system;
- Make public education available to promote and maintain health;
- Provide payment for medications as preventive measures in appropriate circumstances;
- Develop consumer incentives to participate in and take more responsibility for self-care;
- Provide funding to recruit and retain nurses.

Based on their clinical expertise and experience, all groups were emphatic about the importance of including a nursing voice in health policy development and implementation at institutional, state and national levels. Participants viewed themselves and all professional nurses as important resources for policy makers and they wanted policy makers to ask them for their input. This less assertive position may be explained by the training that the participants received at a time when nurses were still expected to be more submissive to physicians and their orders. According to sociologist, Daniel Chambliss, in his study of nurses and the bureaucratic power structures within which they work: ‘If nurses want to be heard, they will have to speak with their own authority, based on their own experience and their own values’ (p. 184).15 Assertive attitudes are already found in younger nurses and new graduates according to the participants. However, assertiveness does not automatically lead to advocacy for patients or participation in policy development. This reality has significant
implications for the current and future education of professional nurses. Participants viewed advocacy for patients and families as a traditional nursing role but worried that this role was being eroded in health care environments focused on cost containment. They thought that patients and families needed advocates to negotiate the complexities and confusion that often exist in the delivery of today’s health care. If nurses did not or could not fulfill this role, patients and families still needed an identifiable person in the organization to provide them with the assistance they needed. Participants did not comment on the fact that many hospitals do employ patient advocates who may or may not be nurses.

The participants emphasized the importance of affordable health care in their discussion and recommendation of universal access for all. Most viewed health care as a human right. At the same time, they stressed a critical need for consumer education to develop more realistic expectations of today’s health care with its expensive and expanding number of technologies. Participants urged that consumers be prepared to assume more individual responsibility for self-care. One emphasized that members of the public need to know that we cannot cure everything or provide everything available for everybody, and viewed this as an ethical issue of justice and fairness. Items for action by legislators and other policy makers illustrate the broad sweep of policy and policy related issues that these participants confront in their daily efforts to provide comprehensive patient care and education and to meet their ethical obligations.

In an assertive stance, the participants urged all of their nursing colleagues to organize and form coalitions to influence policy makers in order to achieve more patient-centred policies. Aroskar asserted that participation in political and policy making processes is an ethical obligation for nurses as professionals and citizens.\(^\text{16}\) The 1976 and 1985 editions of the ANA Code for nurses with interpretive statements stated as a major provision the ethical obligation to collaborate with other professionals and the public to promote broad efforts to meet health needs, especially of people who have unmet health needs.\(^\text{13}\) This obligation, expanded to address issues such as poverty, homelessness and the lack of safe living conditions, is continued in the 2001 revision of the former ANA codes, now renamed the Code of ethics for nurses with interpretive statements.\(^\text{14}\) This recommendation supports the ongoing policy activities of nursing leaders, professional nursing organizations, and policy-related nursing literature,\(^\text{1,2}\) and reflects the ethical commitments of nurses and the nursing profession as stated in nursing’s past and current professional codes of ethics.

Overall, the focus group participants affirmed that nurses who provide or manage direct patient care have critical experience on a daily basis with the consequences of health and health-related policies for patients, families, and nurses that raise concerns about their inability to provide needed care and to meet their ethical obligations as professional nurses. They stressed that nurses’ expertise, their experience in direct patient care, and the nursing profession’s ethical obligations should inform health policy development and implementation in institutions and public policy arenas where health policy decisions are made and interpreted for implementation at the bedside, in the clinic and in the community. Health and patient care policy development and implementation without a nursing voice is policy that lacks a critical element because nurses are the health professionals who care for patients and their families most closely over time. Nurses provide ‘the cement’ that holds care for
patients together. Policy makers ignore this reality to the detriment of patients and their caregivers.

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Mila A Aroskar, D Gay Moldow and Charles M Good, University of Minnesota, Minneapolis, MN, USA.

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