BIOETHICS OUTLOOK

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What Should Patients Be Told?

The Duty to Inform and Advise Patients

Bernadette Tobin

On 19th November 1992 the High Court of Australia unanimously dismissed an appeal by a doctor against the successive findings of the NSW Supreme Court and the Court of Appeal that he was negligent in not informing a patient of a one in 14,000 risk that she might suffer from sympathetic ophthalmia if she underwent a particular operation. In dismissing the appeal, the High Court clarified a doctor's duty to provide patients with information, advice and warnings prior to proposed treatment.[1]

Facts of the Case

The facts of the case were as follows.[2] The appellant was a Dr Rogers, an ophthalmic surgeon. The respondent was a Mrs Whitaker, a patient of Dr Rogers, who became almost totally blind after surgery he conducted on her right eye.

Mrs Whitaker had been nearly blind in one eye - her right eye - since she suffered a penetrating injury to it at the age of nine. Despite this misfortune, she had led a normal life, completing school, working, marrying, and raising a family. In 1983, nearly forty years after the injury to her right eye and in preparation for a return to the paid workforce, she had an eye examination. Her general practitioner referred her to an ophthalmic surgeon who prescribed reading glasses and referred her to Dr Rogers for possible surgery on her right eye.

Dr Rogers examined her and advised Mrs Whitaker that an operation on her right eye would not only improve its appearance but would probably restore significant sight to it. At a second consultation, Mrs Whitaker agreed to have her eye operated on. After the operation, however, there was no improvement in her right eye and, more importantly, she developed inflammation in her left eye. This inflammation, an element of "sympathetic ophthalmia", occurs once in approximately 14,000 such procedures (although the chance of occurrence is slightly greater when - as in this case - there has been an earlier penetrating injury to the eye operated upon). Sympathetic ophthalmia does not always lead to loss of vision. In this case, however, Mrs Whitaker lost all sight in her left eye. As the sight in her right eye had not been restored in any degree by the surgery, she thus became almost totally blind.

Though the judge at the original trial was not satisfied that proper medical practice required that Dr Rogers warn Mrs Whitaker of the risk of sympathetic ophthalmia if she expressed no desire for the information, he concluded, however, that a warning was necessary in the light of her *expressly stated desire for such relevant information.*

Dr Rogers appealed from this decision to the NSW Court of Appeal which dismissed his appeal. He then appealed to the High Court of Australia. The High Court also dismissed Dr Rogers' appeal. In its judgment, however, the Court clarified the extent of a doctor's duty to provide patients with information, advice and warnings prior to proposed treatment. Both the judgment of the High Court and the reasoning it employed in reaching that judgment have ethical as well as legal significance to health care professionals.

Inside

The High Court's Reasoning

The Court started from the well-known legal duty imposed on medical practitioners to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single and comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment".[3] It extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case.[4] The main issue in Whitaker related to the scope and content of the doctor's duty of care.

In order to address this question, the Court had to determine what *standard* of care is entailed by this duty of care, and in particular whether Dr Rogers' failure to inform Mrs Whitaker of the danger of sympathetic ophthalmia constituted a failure to observe this standard of care and thus a breach of the doctor's duty of care.

The Bolam Principle

In his appeal to the High Court, Dr Rogers argued that the question should be resolved by application of the so-called "Bolam" principle (a principle derived from a leading English case[5] decided by the House of Lords).

The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.[6]

The Bolam principle thus recognized that, in matters involving medical expertise, there is ample scope for genuine differences of opinion and that a practitioner is not negligent merely because his or her conclusion or procedure differs from that of other practitioners. More importantly, it resolved the question of what standard of care to apply by reference to responsible (even minority) medical opinion and practice - not to an objective, legal standard. (In the case of Mrs Whitaker, evidence from a body of reputable medical practitioners was given that, in the circumstances of the present case, they would not have warned Mrs Whitaker of the danger of sympathetic ophthalmia. Evidence was also given, however, from similarly reputable medical practitioners that they would have given such a warning.) The Bolam principle has invariably been applied in English courts. However, the High Court determined that Whitaker should not be decided by reference to that principle.

Relevance of the Bolam Principle to Cases of Alleged Medical Negligence

In 1985, the English House of Lords had decided that the Bolam principle should be applied in cases of alleged negligence in providing information and advice relevant to medical treatment.[7] However, though the majority of the Court in fact *agreed* that the question was to be determined by applying the Bolam principle, it is significant that their Lordships differed in how they understood that principle.

- One judge (Lord Diplock) gave the principle wide application, concluding that the decision as to which risks a patient should be warned of was as much an exercise of professional skill and judgment as any other part of the doctor's duty of care to the patient. Expert medical evidence as to the appropriate standard of care could determine the issue.

- Other judges (whose opinions were represented by that of Lord Bridge) accepted that the issue would be decided primarily by expert medical opinion but concluded that, irrespective of the existence of a respectable body of medical opinion which approved of non-disclosure in a particular case, a judge might in certain circumstances decide that disclosure of a particular risk was so obviously necessary to an informed choice by a patient that no prudent medical practitioner would fail to make it.

- Yet another judge (Lord Templeman) was even less inclined to allow medical opinion to determine this issue. He said: "The *court* must decide whether information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered".[8] At the same time Lord Templeman gave substantial scope to a doctor to decide that providing all available information to a patient would be inconsistent with his obligation to have regard to the patient's best interest. This is the doctor's so-called *"therapeutic privilege"*, an opportunity afforded to the doctor to prove that he or she reasonably believed that disclosure of a risk would prove damaging to a patient.

In a dissenting speech, Lord Scarman concluded that the question whether or not the omission to warn constitutes a breach of the duty of care is to be determined *not exclusively* by reference to the current state of responsible and competent professional opinion and practice (though both are *relevant* considerations). It is to be decided by the *court's* view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up his or her own mind in the light of the relevant information whether or not he or she will accept the treatment the doctor proposes.

Why then was there so little support in the Australian High Court for the idea that medical opinion should determine whether or not an omission to warn constitutes a breach of the duty of care? One reason is this: If the Bolam Principle were applied to cases involving the provision of advice or information, it would have the consequence that a patient's enquiries about possible risks or complications would be of little or no significance. And yet it is clear that, over and above the opinion of a respectable body of medical practitioners, the questions of a patient should truthfully be answered (subject to the therapeutic privilege).[9]

The Shortcoming of the Bolam Principle

This indicated a shortcoming in the Bolam approach. The High Court dealt with the problem in Whitaker on the basis that an "acceptable approach in point of principle should recognize and attach significance to the relevance of a patient's question". Even if a reasonable person in the patient's position would be unlikely to attach significance to a particular risk, the fact that a patient asked questions revealing concern about the risk should make the doctor aware that *this patient* did in fact attach significance to the risk. Subject to the therapeutic privilege, the question would therefore require a truthful answer.

Australian Courts Discard the *Bolam* Principle

Even before Whitaker determined how to apply the standard of care in giving patients information, Australian courts in the past decade have accepted that the medical standard of care is determined *not* solely or even primarily by reference to the practice followed or even supported by a responsible body of opinion in the profession. Even in the sphere of diagnosis and treatment, the Bolam principle has not always been applied. Indeed, in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded. Rather the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the "paramount consideration that a person is entitled to make his own decisions about his life".[10]

Medical and Non-Medical Skills

What lies behind the practice of Australian courts? According to the High Court judgment in Rogers v Whitaker, it is a recognition of a fundamental difference between, on the one hand, diagnosis and treatment and, on the other, the provision of advice or information to the patient. Whether a doctor carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often decisive, role to play. Whether a patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is *not*, generally speaking, a question the answer to which depends upon medical standards or practices. For, generally speaking, no special *medical* skill is involved in *conveying* information: the skill is that of *communicating* the relevant information in terms which are reasonably adequate for the purpose of informing the patient (having regard to the patient's apprehended capacity to understand that information).

The Relevant Principle

What then is the relevant principle upon which this question should be determined?[11] The High Court put it this way:

> **"The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege".[12]**

Mrs Whitaker was very anxious about possible complications of the suggested procedure. She was keenly interested in its outcome, including the possibility of unintentional or accidental interference with her 'good' left eye. On the day before the operation, she asked whether something could be put over her good eye to make sure that nothing happened to it. She was apprehensive that the wrong eye would be operated on. She did not, however, ask a specific question as to whether the operation on her right eye could affect her left eye. Thus, though she did not ask precisely the *right* question, she nonetheless made clear her concern that no injury should befall her one good eye.

Moral Significance of High Court Judgment

The legal significance of this High Court judgment will no doubt be debated in the months ahead. However, some aspects of its moral significance are clear enough. The duty of care a doctor has for his or her patient includes both diagnosis and treatment on the one hand and information and advice on the other. As part of this duty of care, the good doctor warns the patient of the risks involved in a proposed treatment or procedure. The nature and detail of the information provided depends importantly on the needs, concerns and circumstances of the patient. Generally, and even if the patient makes no particular enquiries of the doctor (and wants to leave all decisions up to the doctor), a good doctor provides the information which would reasonably be required by someone in the patient's position. When a patient has special needs or concerns which are made known to the doctor, the good doctor provides the appropriate additional information. At the same time, in informing and advising the patient, the doctor has a prerogative to withhold information if divulging it would be potentially harmful to a depressed, emotionally-drained or unstable patient.

Notes

[1] (1992) 109 ALR 625. My account follows closely the analysis of the history and development of the principles as set out in the joint judgment of five justices of the High Court.

[2] There was no question that the doctor conducted the operation with other than the required skill and care.

[3] *Sidaway v Governors of Bethlem Royal Hospital,* [1985] AC 871

[4] *Gover v South Australia, (1985)* 39 SASR 543

[5] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

[6] *Sidaway* at 881 per Lord Scarman

[7] In *Sidaway*

[8] Emphasis added

[9] This is clear from the majority opinion in *Sidaway.*

[10] F v R (1983) 33 SASR 189 at 193

[11] The High Court remarked on the inappropriateness of thinking of the case in terms of "the patient's right of self-determination" and " informed consent":

> "Self-determination is relevant to the issue as to whether a person has agreed to a general procedure or treatment but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure."

and

> ""Informed consent" is apt to mislead as it suggests a test of the validity of the patient's consent. In addition consent is relevant to actions framed in trespass, not in negligence (and in Anglo-Australian law an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass)."

[12] (1992) 109 ALR

Mainstreaming HIV-Positive Patients

Part 2: Is a Universal Body Substance Precaution Impracticable?

John G. Quilter

In June last year, the NSW Department of Health released its policy for infection control for HIV, AIDS and associated conditions in the states's health care facilities. A central part of that policy is "mainstreaming", the arrangement according to which HIV-positive people are treated as ordinary patients (except where secondary infectious disease or advanced AIDS indicates treatment in a specialized unit or in isolated wards).

In the last issue of *Bioethics Outlook* I considered an objection to the policy of mainstreaming which centred on the idea that health care professionals do not have an obligation to expose themselves to unreasonable risks to their health and safety. I considered whether a policy of mainstreaming HIV-positive patients would expose health care professionals to unreasonable risks. I argued that to show that these risks are not unreasonable ones requires more than showing that the probability of infection by an HIV-positive patient is low. (This, of course, is quite easily shown.) We need also to show that the consequences of infection with HIV are at least not very serious. In the absence of a cure for the infection (or AIDS) this cannot be done.

It is, therefore, a matter of reasonable disagreement whether one ought, as a matter of fairness, alert health care workers to the fact that they may be working with mainstreamed HIV-positive patients (whose HIV status is confidential, except on a "needs to know" basis) in order to give these workers the opportunity voluntarily to accept the risks attendant to this work. In addition, I argued that there should be ways of relieving any unfair burdens of exposure to the risks borne by those who are more likely to have to care for HIV-positive patients because of the location and demographics of their work or facility.

Impracticable?

In the second part of this discussion, I shall discuss another objection to mainstreaming. This objection is based on the idea that universal body substance precautions are impracticable. Since mainstreaming involves treating HIV-positive patients just the same as others (with differences arising only on the basis of the sorts of consideration relevant in the care and control of other infectious diseases), it is clear that the policy of universal body substance precautions must be closely adhered to for the sake of infection control. But some people argue that, since it is impossible to maintain universal body substance precautions, a policy of mainstreaming HIV patients is undesirable. They argue that universal body substance precautions unduly distress other patients, and that they are terribly inefficient. Hence, they conclude, mainstreaming is an ill-conceived policy.

Caricatures

There is a temptation to work with caricatures that is evident in a line of thought such as this. On the one hand, people may think of mainstreaming as if it involves, for instance, bringing into a general ward full blown AIDS victims suffering from, say, TB. Nothing could be further from the truth. The point of mainstreaming is that, of itself, HIV-positive status is insufficient grounds for isolating patients or for handling them with total barrier methods. Other factors may be relevant in determining the appropriateness of such treatment. What is right about assimilating HIV to other infectious conditions is that the sorts of indications of non-ordinary patient management are only those that are relevant for handling other infectious diseases (sensitive to the facts about the mechanisms of the virus' transmission).

New reasons for old routines

The caricature of universal body substance precautions is the image of the health care team doing its ordinary activities (e.g., rounds, observations) done up in impermeable gowns, full masks and caps, double-gloved and maybe with gum boots on. Again, this is silly. Universal body substance precautions only require what should be observed anyway. Such practices as frequent hand washing, thoughtful use of gloves if there is real chance of contact with blood or known transmitting fluids, care of one's skin so that lesions be covered well and kept clean, correct cleaning and disinfection after spills etc, and in particular, careful and conscientious management of sharps, used dressings, lab specimens, etc. All this is simply what is required in good hospital care. There is no need for total barrier handling except where it would be used anyway. Thus, rather than representing a reason for adopting a new infection control policy, mainstreaming represents a new reason for adopting an infection control policy that is old.

Now, while this is true and deserving of special re-emphasis, it must also be acknowledged that until the AIDS epidemic, there was a tendency to honour such high standards of hygiene more in the breach than in the strict observance. It is very easy and often convenient to cut corners by not washing one's hands after doing fairly routine things such as emptying a catheter bag or examining a patient's wounds. It is not that mainstreaming HIV-positive patients has forced us to become impractical. Rather, it requires us to live up to what should be happening anyway. Thought may have to be given in the health care system to improvement of the technology for things such as the handling of sharps (no recapping gear, for instance, and better disposal boxes). This will be a change. But, overall, the impracticality objection is rather a reason to lift our game in the mainstream than to discontinue mainstreaming HIV-positive people.

There will remain special situations where universal body substance precautions will probably make some difference. I have in mind such contexts as invasive procedures and surgery. Here, perhaps, new protocols for the disposal of sharps will be required and the use of routine double gloving and protective eye wear and fluid-impervious masks. More assiduous cleaning may be called for between operations in the same theatre to obviate the need for a "resting" period. Perhaps emergency units will need to be routinely supplied with gear of a sort they had not been routinely supplied with before (such as protective devices to prevent direct mouth to mouth contact in CPR for any patient needing it). Again, things of this sort may be new or unusual to some. Even if this is so, it does not follow automatically that what is required is impractical and so to be avoided by avoiding mainstreaming.

Avoiding "Leper Colonies"

The real question is whether such extra effort is *worth* it. That is, is the extra effort or "impracticality" worth the benefits it makes possible to HIV-positive patients to have access to the benefits of mainstreaming?

It would seem to me that it certainly is. What we are asked to balance is the gains to the HIV-positive patient in the sense of normality and self-respect, reliable access to regular hospital and medical care and the like, as well as the gains to the health care system in the high quality of infection control as against the costs in convenience and funds by the system. Of course, there are real risks to the HIV-positive patient implied by mainstreaming. The system of mainstreaming I am defending against this occupational safety objection requires that a system of specialist clinics/units be well maintained and properly funded. Mainstreaming should be a response to the use of specialist units to isolate HIV-positive persons into "leper colonies" rather than an excuse to cut funding for necessary specialist services.

Moreover, alternative policies are arguably worse. HIV-positive patients could sometimes effectively lack access to health care without mainstreaming (e.g. in rural areas). Further, we would leave unaffected the prejudicial stigma attached to HIV-positive status if we isolate HIV-positive persons simply because of their HIV-positive status. Moreover, extra costs that may be necessary for universal body substance precautions may well be off-set by savings due to rationalising facilities that are justified and compatible with the true spirit of worthy mainstreaming. Importantly, mainstreaming

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On our Obligations to the Dependent Elderly

The Dependent Elderly: Autonomy, Justice and Quality of Care

Bernadette Tobin

We often find it hard to think through the moral issues involved in the provision of health care for the elderly, in particular for those among them who depend on the rest of us for their continued care and comfort. Why is this so? One reason is that the moral issues are often genuinely difficult ones. It is easy enough to appreciate the truth in the general moral prohibitions on both killing people and letting them die, and indeed to recognize that these prohibitions are not universal ones. But it is much harder to be able to discern confidently whether withdrawing life-prolonging treatment from this particular patient here and now constitutes either wrongfully killing him or wrongfully letting him die.

Those who find the moral issues in the care of the elderly troublesome will benefit from reading an excellent new book on the subject: *The Dependent Elderly: Autonomy, Justice and Quality of Care.*[1] It is a book of thirteen essays which are based on papers originally delivered at two related conferences on Medical Ethics. The editor, Luke Gormally (Director of the Linacre Centre for Health Care Ethics in London) introduces the collection in what amounts to a paper in its own right. There he points out that three concerns animated the conferences at which the papers were originally given: autonomy, justice and quality of care. In addition to indicating the contents of each of the essays, he also shows how far the contemporary understanding of the value of autonomy has strayed from the moral context which originally gave it its sense and significance. The main ideas discussed in the thirteen essays are: the obligation to provide artificial nutrition and hydration, living wills, the current practice of euthanasia in Holland, the need for long-term care of the elderly, allocating and rationing health care on the basis of age and the usefulness of economics in planning a society's health care.

In order to show just how informative and challenging are the essays in the book, both for moral philosophers and for those with a more practical interest in good health care, I shall outline some of the ideas in just three of them.

In an essay entitled **"The Aged: non-persons, human dignity and justice"**, Luke Gormally starts from the fact that ideas themselves can be very influential. He analyses an argument from contemporary moral philosophy which has practical, and repugnant, consequences for the demented elderly. This is the argument which combines one idea (that only human beings who have *presently exercisable* abilities for reflection, choice and communication are genuinely "persons") with another (that only human "persons" possess human rights, in particular, the right not to be murdered) in order to conclude that there is no intrinsic objection to killing the senile elderly. As he says, it was the philosopher Bernard Williams who decisively showed how this attempt to connect basic human rights with the possession of "personhood" is a recipe not for justice but for the arbitrariness characteristic of injustice.[2]

Economics v Economism

In **"Economics, justice and the value of life"**, John Finnis points out how helpful disciplined economic thought can be. It reminds us that to spend our resources (time, labour, money, effort, etc.) on *one* thing is to use up the very resources which we might have spent on *other* things. However, when this disciplined economic thought becomes infected with what he calls "economism", it produces ideas which are confused and which practically-speaking tend to undermine our commitment to the care of the dependent elderly. Economism is the idea that *ethical* issues can be settled by economic reasoning. It involves the fallacy of thinking that the goods achievable by human action can be added or subtracted on a *single* scale and that one can work out which of two actions *maximizes* value. So, for example, a health care economist whose thought is infected by "economism" may try to discover which of the following two choices would maximize value: (a) letting someone who is permanently and irrecoverably unconscious die or (b) continuing to provide that person with life-supporting treatment. But if, in trying to estimate "the overall value of discontinuing treatment" the economist were to add (say) the financial cost of providing continuing care to (say) the prolonging of the family's suffering and to (say) the indignity the patient suffers in living human life in this way, he engages in fallacious arithmetic. For even if it were true that discontinuing treatment had, in a particular case, these three things to be said in its favour, one could not treat them as items in the same sum. The good things achievable in human action cannot be weighed and measured in this way. For there is no scale according to which we can compare the value of benefitting the patient by sustaining (or withdrawing) treatment with the value of prolonging (or relieving) the family's suffering. The most one can say is: "Is continuing treatment to a person in this patient's position a benefit which, all things considered, is worth seeking and having?"

In one of the best articles in the collection (**"Should age make a difference in health care entitlements?"**) Joseph Boyle analyses several arguments which are advanced in favour of the idea that a person's age is a morally-relevant consideration in decisions about his or her treatment. He devotes particular attention to an argument advanced by Daniel Callahan.[3] Callahan thinks that, even if there were no pressure on resources, we would still have reason to limit the forms of medical care available to people in their old age. In a good society, one in which there were some measure of communal agreement about the meaning and significance of human life at its various stages (and, in particular, some agreement about the meaning and significance of *old* age), we would share a sense of what constitutes a "natural lifespan" and the elderly themselves would have a sense of when their lives were substantially complete. In a good society, the elderly would be supported in their acceptance of human mortality. They would be ready to reject essentially life-prolonging treatments once their lives were substantially complete.

Boyle starts by pointing out how, inspite of Callahan's claim that his thinking does not derive from the conviction that some kind of rationing of health care is now necessary (even in wealthy societies), there is an enormous amount of talk in his book about the costs of health care (in particular to the elderly) and the consequent necessity for working out a just distribution of care. He goes on to show that Callahan's main argument uses the notion of the limits to health care that *some* old people would be prepared to accept as grounds for limiting the forms of health care a society is obliged to provide for *all* old people. No doubt Callahan would reply that he is less interested in imposing limits on the forms of health care available to the elderly than he is in showing how imprudent our desires for life-prolongation can sometimes be, in particular when we are elderly. But it is hard to see how he could save his argument from Boyle's criticisms.

There is much more in this book which deserves careful reading and reflection. In common with other publications from the Linacre Centre in London, the essays are informative (especially about the care of the elderly in the United Kingdom) and rigorously-argued. And even where the reader's thinking differs from an opinion expressed by one of the authors, that thinking will surely be clarified in engaging with the author's thinking. I warmly recommend the book.

Notes

[1] *The Dependent Elderly: Autonomy, justice and quality of care*, edited by Luke Gormally, Cambridge, Cambridge University Press, 1992

[2] Williams, B: "Which slopes are slippery?" in *Moral Dilemmas in Modern Medicine*, ed. M. Lockwood, Oxford , Oxford University Press, 1985

[3] Callahan, D: *Setting Limits: Medical Goals in an Aging Society*, New York, Touchstone, 1987

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Collegiality in Nursing

Mary Chiarella

The issue of collegiality in nursing has prompted many trains of thought for me during the preparation of this paper.

In 1974, I was an anaesthetic nurse at the Radcliffe Infirmary at Oxford. The College of the Medical School at Oxford was called Osler House, after the eminent surgeon, Sir William Osler. Osler House had very beautiful lawns, a beautiful tower, and the Osler House Bar. The Bar was particularly significant for it belonged to the students. Surgeons and nursing staff, physicians and anaesthetists, physiotherapists and anyone else who was not a medical student and who wanted to have a drink there had to be invited in by a student. Since Osler House Bar was a very nice place to drink, and the drinks were all subsidised, this gave the students tremendous status.

Equality and Mutual Respect

What always struck me about it was the sense of equality and of mutual respect that this neutral territory gave to the group. Nobody was better than anybody else. The students were polite to all their guests, and the guests, naturally, were polite to their hosts. The whole atmosphere was one of a rather exclusive club. At the time the term I thought most appropriate was: a sense of collegiality. In order to explore collegiality in nursing, we have to ask two questions. Firstly, what is collegiality? Secondly, does a sense of collegiality exist in nursing? I shall argue that we can only develop a sense of collegiality in nursing if we feel that we are privileged to belong to the institution of nursing.

Obstacles to Collegiality

Are there obstacles in the way of nurses thinking of themselves as privileged? Is it true that many nurses would be surprised if someone were to say "Aren't you lucky to be a nurse"? Is it true that we do not feel privileged to belong to the nursing club? Why do we sometimes feel awkward about saying that we are nurses - even a bit embarrassed or ashamed?

We are a young profession, indeed a profession in its adolescence. Adolescence is a time of insecurity about identity, and some of the things we have learned about ourselves as a profession may well make us feel insecure. For one thing, we have developed a conscience about the way we sometimes used to manage patients in the past. No doubt most nurses have felt uncomfortable about some of the activities our senior colleagues got up to: "Being cruel to be kind" it was often called. Indeed, some of us may have adopted similar management strategies. I can well remember, after a spell of rest and recuperation in theatres, going back to a ward as a staff nurse where I had worked as a third year student nurse just before my finals. I was carbolising a bed in a side ward, when I suddenly had a flashback of dragging a very sick man with multiple sclerosis out of the same bed two years previously. He desperately wanted to stay in bed and indeed two people were needed if he was to be gently handled out of bed. But I would not hear a word of it. He came out of the bed as I shouted at him to stand up. As I stood and remembered the incident, I was choked with shame. I think most of us would harbour a few memories like that, memories which haunt us when people say: "Oh, you must be angels - I could not possibly do nursing".

An Ethic of Obedience

In addition to this, there was the "conspiracy" problem. Sometimes it seems that nurses really did not have any ethical dilemmas until 1974 when the American Nurses' Association changed one word in its Code of Ethics. Instead of saying that nurses had a duty of loyalty to the physician, the new Code of Ethics said that nurses had a duty of loyalty to the patient! (Nobody, however, told the doctors!) Prior to that, the predominant ethic in nursing was an "ethic of obedience": you were a good nurse if you did as your superiors told you and, since you learnt pretty quickly that everyone was superior to you, obedience to everyone stood you in very good stead!

But then we nurses started to read the "radical mags", and these told us we had to develop a conscience and protect our patients - advocacy and autonomy became the buzz words. Though we recognized the appropriateness to nursing of these two ideas, we felt that we were now being told that the way we had done it up to now had been wrong, and that made us feel guilty.

The other unpleasant thing that we recognised about ourselves in this period of adolescence was that we were unkind to each other - disloyal, bitchy, unsympathetic. I have often been told that I belong to a profession that eats its young. I once asked someone why nurses were so unkind to each other: the reply was that it was because nurses were all women. I was inclined to believe that there was some truth in this until, in the late 1980s, I first heard Maria Vidovitch speak about the sociology of oppressed groups. The more I read on that subject, the more it helped me understand the nursing profession.

What my readings taught me was that neither nurses nor women were intrinsically cruel. They did not behave in those unkind ways because of their double X chromosomes. They behaved like that because they were oppressed. Indeed, men who are oppressed behave in just the same way - emulating their oppressors, being polite to their faces whilst talking about them behind their backs, and siding with their oppressors against their own when they themselves came under threat. The folk culture of nursing still glorifies oppression: "Do you remember Sr. Styles who used to scream at us from the top of the ward?" There is a risk that this makes us feel feel ashamed of our profession, and not very privileged to belong to it. Indeed, this feeling is reinforced by the attitude of some doctors. Take for instance the reaction of some doctors to the recent nurse practitioner review: "After all we've done for you, this is how you repay us!" Several doctors have demonstrated a Darwinian-style racial superiority theory of medicine, which has indicated their deeply-held beliefs of their own profession's superiority.

But in fact the nurse practitioner review is an indication of our maturity. It marks our new self-confidence. We want legitimate recognition for those activities which many of us have carried out for doctors for so long. We want people to know it the way it really is. The nurse practitioner review is a true sign of our maturation, of our new readiness to state our case with dignity, without apology, and to risk the wrath, and indeed on some occasions the abuse and scorn, of others in so doing.

The Privileges of Nursing

There are many more things for us to feel proud about. We have a tremendous record of innovation. We were leaders in quality assurance. We are leaders in the competency movement. We need to advertise those facts. We also need to capture the attention of the media to get some better press for ourselves. In order to do that we need to identify what we are good at, what marks us out as a distinctive profession, what in fact are the privileges of being a nurse.

Intimacy

The first privilege is the privilege of intimacy, the privilege that comes from hands-on nursing. Recently, I heard Bev Taylor from Deakin University describe a scene in the shower between a nurse called Elizabeth and a big German woman called Coralina. The detail of the description was such that there could not have been a nurse in that room who was not imaginatively in the shower with Coralina. The beauty and intimacy of the vignette was nursing at its best, at its most private, and yet made public in a way that demonstrated to the world the intimacy and the blend of art and science which is skilled nursing care. Bev was using her literary skills to glorify our nursing practice in a way which will benefit all nurses. It not only raises our consciousness; it also raises the consciousness of the general public about the privilege of nursing. Gael Knepfer and Carolyn Johns's book *Nursing for Life* does the same thing. It gives an insight into real nursing care which the world often misses and because the popular media generally concentrate on nurses interacting with doctors rather than with patients.

We can also demonstrate tremendous team spirit. particularly when there is a job to be done. Some of my most treasured working moments have been spent in times of huge workload working with other colleagues, whether on the wards, in the operating theatres, or indeed in such special projects such as writing university curricula. Nurses are good at working very hard. We do it very well and with a tremendous sense of camaraderie and humour. It was interesting to note that, in England, when nursing graduates were going through an employment crisis, Marks & Spencers snapped them up for their own management training programme: nurses' organisational and interpersonal skills were so good. Nursing also provides a diverse choice within its own structure. It offers scope for those who want to work as clinicians, to those who want to do research and to those whose special talent is teaching.

And so we need to learn to feel pride in our profession. We need to learn to be decent and kind to each other. We need to be proud of our managers, our researchers, our thinkers, our doers, our retired nurses and our undergraduates. And we have to value our profession. A 3rd year undergraduate, who was having difficulty with a nursing case history, said: "I don't care about how well I do. I just want to scrape through". My colleague, helping her, retorted: "Some of the best and most wonderful people I know are nurses. If you can't be bothered to try your best, you're not the sort of person we want in nursing!" The fact that nurses are saying these things is an indication of the turning of the tide and of the development of collegiality in nursing. We must be sure that we too support this development.

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Notes

* Mary Chiarella is Director of ContinuingEducation and Special Projects at the New South Wales College of Nursing. This is a shortened version of a paper originally pressented at the 1992 Annual conference of the Institute of Nursing Administrators of NSW & ACT.

* Taylor, B: "The Colours and Patterns of the Nurse-Patient Relationship: a delightful and dynamic relationship". Paper presented at the First National Nursing Forum of the Royal College of Nursing, Adelaide, 1992

* Knepfer, G & Johns, C: *Nursing for Life*, Sydney, Pan Books, 1989

Mainstreaming HIV-Positive Patients

Continued from Page 6

affords more reliable and accessible heath care choices to the HIV-positive patient which would otherwise be unavailable.The impracticality objection is weak. Though its real implementation may indeed require good will on the part of health care administrators and professionals used to less than universal body substance precautions, the policy does have the weight of the argument on its side.

Two Further Issues

There are two further serious questions which need to be asked about the policy: Firstly, there is a danger that the good features of mainstreaming will be used as an excuse to cut necessary specialised services. Secondly, there is the question of the dissemination of the information concerning the HIV-positive status of the mainstreamed patient. The patient's right to confidentiality is part of his or her right to self-determination; here, it is the right to control who has knowledge of information about oneself. It is reasonable that certain health care workers be told in order for them to be able properly to care for the patient and ensure that proper infection controls are observed.

Conclusion

Finally, we must admit that mainstreaming exposes the HIV-positive patient to risks of unjustified breach of confidentiality and the discriminatory behaviour of others. Hence, it is important that the basis of identifying which health care workers may be informed of the HIV-positive patient's HIV status be thought through carefully. Usually, the basis is described in terms of the "need to know".

However, this tag only raises the question, it does not answer it. The question is: Why does anyone need to know the HIV-positive status of the mainstreamed HIV-positive patient? Do all the reasons mentioned above justify informing health care workers of a patient's HIV status? Are there other reasons?

These are questions for another occasion.

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NOTEBOOK

Changes at the Centre

Following the official signing in December last year of the Memorandum of Association between Australian Catholic University and St Vincent's Hospital, Sydney, the position of Director of the John Plunkett Centre for Ethics in Health Care has been advertised for the first time. Applications for this position closed at the end of January.

Dr Gerald Gleeson, who has been Co-Ordinator at the Centre for the last fifteen months, has resumed his teaching duties in the Catholic Institute of Sydney (Manly), but will continue as a part-time Research Fellow at the Plunkett Centre with a special interest in the contribution of moral theology to health care ethics.

Ms Colleen Leathley, a Research Associate at the Centre for the last two years, has recently completed a project on patient and staff perceptions of the culture of a teaching hospital. Colleen's contract with the Centre has now come to an end, and she is currently visiting Israel, Europe and West Africa. We shall miss her company, and also her intelligent capacity to manipulate our word-processing and desktop publishing software.

Advance Notice of Public Seminar

What Should Patients Be Told?
The duty to inform and advise.

Advance notice is given of a
public seminar to be sponsored by the
John Plunkett Centre for Ethics in Health
Care
Tuesday, 22 June, 1993,
at
St Vincent's Hospital,
Victoria Street, Darlinghurst NSW
3.30 to 6.30 pm.

For further information, including details of reservations, cost, etc., please contact

Heather Curry
(02) 361 2869 or (02) 361 2793
Fax (02) 361 0975

Proceedings of Seminar on Resource Allocation

Copies of the Proceedings of the seminar:
"Resource Allocation: the Ethical Issues"
are now available from the John Plunkett
Centre.
$10 ($8 for Subscribers)

Melbourne Bioethics Seminar Programme 1993

Mondays 4.30 - 6.00 p.m. Lecture Theatre 1, Mercy Campus,
Australian Catholic University, 412 Mt Alexander Rd, Ascot Vale, Victoria

15th March "Teaching Facts and Teaching Values"
Mr Chris Mulherin, Royal Melbourne Institute of Technology

22nd March "Resource Allocation: The *Ethical* Issues"
Dr Bernadette Tobin, John Plunkett Centre for Ethics, St Vincent's Hospital, Sydney

29th March "A Fundamental Ethic of Health Care"
Sr Regis Mary Dunne RSM, Provincial Bioethics Centre, Catholic Dioceses of QLD

5th April "Ethical Issues associated with the Menopause"
Dr Paul Komesaroff, Baker Medical Research Institute, Melbourne

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