Announcement

The Editors are pleased to announce the appointment of Mila Ann Aroskar, R.N., Ed.D., to the Editorial Advisory Board of *Nursing Law & Ethics*. Dr. Aroskar is widely known for her writings on health care ethics, is Associate Professor of Public Health Nursing at the University of Minnesota's School of Public Health, and is the author of this month's lead article on professional autonomy.

Autonomy *Continued*

of his decisions and actions. This does not support providers "covering up" for each other when errors have been made. In the professional model, accountability for behavior co-exists with increasing autonomy. Professionals gain and maintain control over their practice by being answerable to their clients. Professionals do this as a body, to assure safe practice in the best interest of clients, through the development of codes of ethics which provide guidelines for defining professional responsibility in the client-provider relationship, by setting rigorous qualifications for entry into practice, through requirements of peer standard setting such as the *A.N.A. Standards of Practice*, and through practice acts and legal definitions of liability which inform the public and providers of the duties and obligations of professionals.

If nurses are to adopt this complex of autonomy and accountability in practice, then we must develop organizational structures in which this objective can be achieved. Most current health care settings do not foster the development of autonomous and accountable collegial nurse practice. For example, nurses have been delegated administrative authority and accountability but have not been granted, or taken, responsibility for their own patients in most institutional settings, a catch-22. Traditionally, nurses have not been expected to make professional decisions at the staff level; decision-making has been located at the supervisory and administrative levels.

Changes in Nursing Systems: Autonomy/Accountability

Changes are occurring in organized nursing services and in nursing roles in a variety of systems. One example is primary nursing where one nurse is accountable for the around-the-clock care of a group of patients. The primary nurse is nursing's representative in dealing with other members of the health care team. Patient advocacy is also viewed as a part of this nurse's role since the primary nurse is concerned with quality of nursing care even when not on duty. Contracts are made with peers and clients in which duties and obligations are spelled out for all parties, a relationship of more explicit reciprocity.[2] This is in direct contrast with the paternalism of the traditional medical model in which decisions are made *for* clients rather than *with* them — a practice which seriously limits the patients' autonomy.

A second example of organizational change that is compatible with improving patient care and assuring professional nurse autonomy and accountability has been tested at the Iowa Veterans' Home in Marshalltown, Iowa.[3] This is a long-term care facility where nursing is the primary service. Organizational conditions have been established to enable nurses to control and regulate nursing practice in several ways: decentralization of authority and responsibility in the nursing department; identification of professional nurses as peers rather than as supervisors and supervisees; and assignment of nurses to specific patients with accountability for all care given to the patient. Nurse peer review and collegial decisional authority with regard to nursing care are critical components of the organization. While the struggle to achieve these changes has not gone unchallenged by medicine, their success seems demonstrated.

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As we strive for professional autonomy, a profound and recurring issue in nursing and health care — relationships between physicians, predominantly men, and nurses, predominantly women — presents itself. These relationships historically and traditionally have been authoritarian — culturally, institutionally and professionally. Starting with Nightingale, and throughout the last century, nurses have challenged this tradition. But the majority of nurses have remained passive acceptors of the status quo, responders to physician orders, patient needs, and the demands of agency administrators and third party payers. Nevertheless, the growing edges of nursing — the demonstrated effectiveness of nurse

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