

## **Les notions d'économisme, d'efficacité et d'écologie morale dans le cadre de pratiques infirmières saines**

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La rhétorique du marché concurrentiel qui domine les discussions en matière de politiques de santé aujourd'hui identifie les produits et les services médicaux comme des commodités destinées à être consommées par le public, qui les achète ou ne les achète pas, selon le prix. Les systèmes de soins sont révisés et les hôpitaux restructurés sous l'angle de l'accroissement de l'efficacité et de la productivité. À partir des expériences des infirmières cliniciennes œuvrant aux États-Unis, cet article démontre comment l'application de la notion d'économisme à la profession peut gravement porter atteinte à l'écologie d'une pratique infirmière saine et rend difficile le maintien de normes de soins minimales. De plus, elle limite sérieusement les gestes de compassion qui doivent être posés lorsque les gens vivent la maladie, la perte et la mort. Des préoccupations portant sur la responsabilité morale et les oppositions entre objectifs institutionnels et objectifs infirmiers sont émises. La présence d'une méfiance de plus en plus grande face aux systèmes de santé de la part des praticiens, des patients et des familles suggère que le temps est venu de se pencher attentivement sur la question de l'écologie morale dans le domaine des soins infirmiers.

# Economism, Efficiency, and the Moral Ecology of Good Nursing Practice

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The free-market rhetoric dominating health-policy discussions today frames health-care goods and services as commodities that consumers will or will not buy at a given price. Health-care systems are being redesigned and hospitals restructured with a view to increased efficiency and productivity. Drawing on the experiences of clinical nurses in the United States, this paper shows how the application of economism to nursing may severely disrupt the ecology of good practice, leading to difficulties in meeting minimal standards of nursing care and severely constraining the acts of compassion called for by the human experiences of illness, loss, and death. Concerns about moral responsibility and conflicts between institutional and nursing goals are described. Increasing mistrust of health-care systems on the part of practitioners, patients, and families suggests that it is time to attend closely to the moral ecology of caring practices.

*A lot of issues that are simply monetary for a lot of people around us, above us, below us, are completely ethical and moral for us. I find that particular situation is the most difficult situation for me as a professional, and it's getting worse and worse.*

– Registered nurse practising in the United States

Over the past two decades, proponents of free-market competitive models of health care have argued with unwarranted optimism that such models are the answer to accelerating health-care costs in the United States (Ellwood & Enthoven, 1995; Enthoven, 1981, 1988). These models have been the subject of considerable criticism based on the conflicts of interest they can cause for physicians, the way in which they have changed the locus of clinical decision-making, and the economic threat that market-based institutions pose to safety-net services for the uninsured (Kassirer, 1995, 1996; Malone, 1999; McKenzie & Bilofsky, 1994; Mechanic, 1996; Relman, 1992; Smith & Lipsky, 1992; Socolar, Sager, & Hiam, 1992). Even in countries with excellent public health-care systems, such as Canada, ideological pressures for privatization and competition raise similar concerns. The discussion of competitive, market-based models has focused on the relationship between physicians

and patients or between physicians and payers, as though these were the only actors. Yet clinical nurses occupy a unique place in the health-care system. As has been noted elsewhere (Andre, 1998), they hold a central and morally difficult position insofar as they act as interpreters between patient, family, physician, and system; bear a largely unacknowledged responsibility for critical, moment-to-moment decision-making; and spend more time than other health-care providers in direct contact with patients — yet have little structural power to alter the institutional conditions under which they practise.

Nursing as a practice carries both practical and symbolic meanings, embedded in an ethic of caring for vulnerable, commonly ill or injured, others (Benner, 1994a, 1994d, 1997; Benner, Tanner, & Chesla, 1996; Benner & Wrubel, 1989). To become educated and socialized into any practice is to develop the skills, knowledge, and character traits suitable for that practice. However, caring professions such as nursing, medicine, and social work are socially organized: institutional structures and spaces support them and facilitate their passage to successive generations of practitioners (Malone, 2003). A practice embodies more than technology and science, more than individual knowledge and technique. Practitioners adopt styles and patterns of relating and attending to those they serve. Social institutions play an important part in the quality of caring practices, in that good public institutions and good citizenship are mutually supportive:

The relationship between compassion and social institutions is and should be a two-way street: compassionate individuals construct institutions that embody what they imagine; and institutions, in turn, influence the development of compassion in individuals. As both Rousseau and Tocqueville show, empathy and the judgment of similar possibilities are profoundly influenced by the ways in which institutions situate people in relation to one another... Similarly, institutions teach citizens definite conceptions of basic goods, responsibility, and appropriate concern, which will inform any compassion that they learn. Finally, institutions can either promote or discourage, and can shape in various ways, the emotions that impede appropriate compassion: shame, envy, and disgust. (Nussbaum, 2001, p. 405)

Here, Nussbaum outlines the shape of a moral ecology, calling attention to the way in which institutions structure moral action. Moral activity, in turn, shapes institutions. Caring practices develop not in a vacuum but within specific institutional settings. Nursing takes place almost entirely within institutions: hospitals, home-care agencies, public health departments, and schools. How these institutions are structured, and the orga-

nizational values they embrace as primary, directly affect the practice of nursing.

### **The Ecology of Practice**

Aristotle (1985) made a distinction between production and practice. The making of things can be reduced to narrow, rational technique, whereas practice is relational and entails a responsibility to do right by others. A practice has goods that are internal to it; these notions of good are socially embedded in the teaching and expectations of practitioners (Dunne, 1997; MacIntyre, 1981). In this view, individual practitioners are members rather than competitors seeking independent goals; they must be open to experiential learning and ongoing education and research. Experiential learning involves the recognition of failures and errors as well as insight and innovation. In forming habits, thoughts, and actions, the practitioner envisions and adopts the standards of good practice.

Experiential learning in a complex and rapidly changing practice is necessarily risky and expensive. It is irresponsible for practitioners to keep innovations or errors a secret from colleagues because, as members of a socially organized group, they hold joint responsibility for continually improving the practice (Rosner, Berker, Kark, Potash, & Bennett, 2000). The practitioner develops traits and skills that are characteristic of excellent practice in order to achieve the ends of the practice. Just as an athletic team trains in order to achieve mental and physical mastery of the sport and a coordinated response, so the practitioner develops the character and skills to be a good practitioner. To be a good practitioner is to embrace the structures and processes that embody the principles of good practice and that organize a community of practitioners around common goals. We suggest that the interaction between a practice and the institutions upon which it depends constitutes a moral ecology, and that critical examination of the ecology of nursing practice is essential to its survival. In this paper, we analyze data from qualitative research findings to show dimensions of the ecology of hospital nursing practice in the United States under conditions of increasing cost-containment.

By moral ecology, we mean the institutional influences that shape the social and moral working environment. Ecology, as a concept derived broadly from the environmental movement, asserts that an endangered plant or animal cannot be considered in isolation; it must be considered in terms of the ecosystem of which it is a part. Thus the concept of an ecology of nursing practice implies temporal and moral dimensions, in addition to the physical, institutional dimensions that are essential to good practice.

In an ecological approach, particular attention is paid to aspects of caring work that resist abstraction and commodification (Donnelly, 1995). Such an approach also considers the goal of *sustainability*, although how that is to be defined is a matter of ongoing ideological and theoretical debate (Norton, 1995). It seems reasonable to assume that as a society we have a basic interest in healing those who are sick or injured and in maintaining health, and thus should consider how to sustain the kinds of practices that support these aims. In a sustainable moral ecology of good nursing practice, or of any health-care practice, the etiquette and social norms of the institutions will be congruent with the ethics and ethical comportment of its members (Benner, 1994b; Day, 2001; Day & Benner, 2002).

### Methods

This paper reports findings from the second phase of an interpretive phenomenological study of skill acquisition and clinical and ethical reasoning among nurses caring for critically ill patients in the United States (see Table 1). The first phase, Expertise in Nursing Practice, articulated the knowledge embedded in critical-care nursing practice, the exercise of clinical judgement, and the acquisition of skills (Benner et al., 1996). The second phase, Teaching Critical Thinking and Clinical and Ethical Reasoning, extended the first phase and coincided with dramatic changes taking place in the US health-care system and in critical-care nursing under the expansion of managed care and the market model during the mid-1990s (Benner, Hooper-Kyriakidis, & Stannard, 1999). The second phase updated the earlier findings and also included areas of critical care not covered in the first phase: burn intensive care, neurologic intensive care, emergency care, flight nursing, operating-room nursing, post-anesthesia care, and home care. In the second phase we interviewed 75 nurses from 20 hospitals and one home-care agency and observed a subsample of 31 nurses in their practice, documenting critical-care nursing at a time of extreme destabilization of health-care delivery.

Audiotaped interviews were conducted with nurses individually and in small groups. The participants were asked to share episodes in their practice in which they felt they had made a difference or learned from the experience. The observations of the subsample of nurses in their everyday practice were conducted by trained nurse ethnographers. Transcriptions of both the interviews and the nurse ethnographers' notes were analyzed with a view to exploring the context in which the episodes described in the interviews took place. The study was approved by the University of California at San Francisco Committee on Human Research and all nurse participants provided written consent prior to being interviewed or observed. To protect confidentiality, names and

<b>Table 1 Phase One and Phase Two</b>					
	<b>Dates</b>	<b>Hospitals</b>	<b>Home-Care Agency</b>	<b>Nurses Interviewed</b>	<b>Nurses Observed*</b>
<b>Phase One</b> Expertise in Nursing Practice	1988–92	8		130	48
<b>Phase Two</b> Teaching Critical Thinking and Clinical and Ethical Reasoning	1996–97	20	1	75	31
*Subsample of nurses interviewed.					

identifying information are omitted from this report. In both phases of the study, data collection and analysis were guided by the following aims:

1. To delineate the practical knowledge embedded in expert practice
2. To describe the nature of skill acquisition in critical-care nursing practice
3. To identify institutional impediments and resources for the development of expertise in nursing practice
4. To begin to identify educational strategies that encourage the development of expertise (Benner et al., 1996)
5. To articulate the nature of knowledge and interventions in critical care.

(Benner et al., 1999, p. 6)

As well as confirming many of the findings of the first phase, the second phase revealed new means of acquiring and sustaining moral agency in the face of economic restructuring. The interview and observational data on skill acquisition and clinical and ethical reasoning included large segments on the disruptive effect of economic pressures and downsizing. By analyzing these segments using interpretive approaches described elsewhere (see Benner, 1994c; Benner et al., 1996), we identified new themes capturing the effect of institutional changes on nursing. This paper presents an interpretive analysis of thematic data on disrupted nursing practice in the face of new economic pressures.

## Findings

In the hospitals studied, system reorganization had been undertaken in response to perceived market pressures to be more competitive and minimize staffing costs. This had resulted in hiring freezes, staff cuts, and altered work expectations. The altered working conditions disrupted the continuity of specific nursing units. An Adult Critical Care Clinical Nurse Specialist (CNS) drew attention to the additional labour needed to compensate for the disruption:

Interviewer: *What is the size of your staff?*

CNS: *We have a lot of [vacancies]. We couldn't hire for so long...so we have per diems [nurses hired by the day], floats [nurses not regularly assigned to any one unit], new people. And they're great nurses! But we don't have that...core group of people that...all knew the standards, and so we're doing some standards revisions on the [leadership] committee right now... We're working on that, but it's also saying, "What's realistic today...in practice? Do you mount strips [the practice of incorporating EKG recordings into the patient chart at regular intervals]? How frequently?" I had the staff nurses calling other institutions in [the area] to find out... And saying, "Is this really possible to do any more?" Because it doubles [nurses caring for twice the number of patients they are customarily assigned] like crazy in here, and it's not regular staff. So we have to really look at what we're doing. When I started in critical care we checked capillary refill [examining how quickly and adequately capillaries refill after pressure is applied to the fingernail, a sign of the patient's perfusion] every 2 hours and wrote it down once a shift and PRN [as needed]. Do we really need to do that for every patient, and when does judgement, nursing judgement, come in? We have to give them a base to start from: "This is the minimum." But then, from there...nursing judgement has to come in.*

The core group to which the CNS refers is a community of caregivers who have shared understandings, standards, and visions of good practice. Such a community forms a socially embedded ethos and style of vigilance. The group recognizes blind spots and weaknesses as well as strengths, and cross-monitoring serves to strengthen, augment, and correct (Risser, Simon, Rice, & Salisbury, 1999). When the group is composed of per diem workers and floats, and when turnover is high, the community of vigilance and internal control is disrupted. Nurses working on the same unit are unfamiliar with one another's practice style, pace, and special abilities; thus, shared understandings must be replaced with written standards. The word *standards* as used here suggests a minimum level of safety. When standards are lowered to fit the reality of

minimal staff resources, rather than being established on the basis of safety requirements and excellent practice, their meaning and social function are reversed.

There is a conflict here in that written standards are brought in to make up for the gaps in knowledge and continuity caused by the loss of the core group. When expectations are lowered to a minimum, nurses must rely on their “judgement” to decide whether additional measures are needed. This requirement for judgement comes just when there are fewer nurses and fewer institutional supports to ensure the kind of stable staffing and continuity that foster good judgement. The ecology of good nursing practice thus appears to be disrupted, as “flexible” staffing serves to minimize familiar and relational knowledge exchanges.

The institutional value systems under which nursing is practised must sustain some congruence with both cultural and practice values. This *moral* ecology of practice warrants close attention, because it is critical to the socialization of new practitioners. As unit stability diminishes, so too does the ability of practitioners to maintain reasonable standards:

*Nurse: I've brought my standards down, too, a level. But there's a minimum, you know, a bottom that I won't go past. And it's very frustrating to witness.*

*Interviewer: When you say “standards,” what exactly are you talking about?*

*Nurse: About the level of nursing care that's provided in terms of assessment, interventions, and even documentation... If a patient has a dressing on, then I expect the nurse to know or find out what's under that dressing... What happens now is [a nurse may say], “The docs didn't write an order to change anything,” so they just leave it. And that can't be an excuse... In the past, nurses were always either saying [to physicians or to each other], “Well, that's the wrong dose,” or “Hey, you haven't addressed [the fact] that this person is a diabetic and we haven't checked any sugars yet.” [Now there are] oversights, many oversights.*

This nurse calls attention to the fact that cross-monitoring requires time, staff, and/or familiarity among practitioners. Contrary to constricted views of nursing practice as merely carrying out the orders of physicians, nurses do recall, check, question, and verify the treatment decisions of physicians and other nurses. However, staff instability and the need for increased efficiency make this kind of monitoring difficult to sustain, and nurses noted that there seemed to be little institutional recognition of its importance to their clinical roles.



In one small-group interview, the nurses said that the focus of nursing leadership meetings had shifted to organizational and system changes, to the extent that there was little discussion of clinical issues:

First nurse: *Our focus is on team-building, incorporating PCAs [patient care assistants] and care assistants, and whatever else, but not about clinical care for years, a couple of years probably...*

Second nurse: *...it was the first time we talked about anything clinical in...I don't know, a year and a half.*

First nurse: *We've spent a lot of time learning about the health-care systems out there...about all services, all the different levels of care, all the different insurances, all the new review processes... Most of it we need to know, but it was all going to that, and how you can use your computer now that you've finally got one so that you can enter that you've given a review to the insurance company. I mean, all this time on that stuff and not at the bedside, and clinical care has suffered.*

System redesign often displaces direct clinical care and increases nurses' responsibility for supervising the non-licensed personnel who have stepped into bedside roles. However, it also creates new clinical education needs, as illustrated in the following discussion by an intensive-care unit (ICU) nurse about the move to place more critical patients on regular units:

*With the whole managed care, they are asking [us] to make changes without any support. An example is on our acute floors. Now they take [patients with] dobutamine infusions, dopamine infusions [both are intravenous vasopressors to maintain blood pressure and cardiac output], and Pronestyl infusions [an anti-arrhythmic medication]. And it just happened, and they didn't change the staffing ratio, yet the patients have to be monitored more frequently. They [nurses on floor units] didn't get education. There's no educator. I mean, they didn't get a formal education [planned inservice]. It was all kind of thrown out there. And the patients are put on mechanical ventilation, a bi-pap format [a type of ventilation in which endotracheal intubation is not required] on the floor [regular unit]. They call me, "Can you come see this patient?" There's no planning, it's just "gotta push them out," and we're pushing patients out of the ICU because we need the bed, and then they are still critically ill.*

Not only is the core group of practitioners disrupted, but patient allocations are changed, so that nurses are responsible for more acutely ill patients and are expected to administer therapies for which they have received little or no training.

### ***Compressed Time for Contact and Connection***

Weber (1964) forecasted the problem of the relational and the moral being overlooked in the drive towards ever more efficient systems. The human functions of vigilance, engagement with others, and commitment to excellence may also be overlooked as means are separated from ends and efficiency is disassociated from efficacy. In the systems engineering approach, differences in temperament and skills are minimized and human beings are treated as standard units of labour rather than as unique resources for the teaching and advancement of good practice. Demoralization of the work group can occur when informal leadership patterns are disrupted, significant aspects of the work are overlooked in the redesign, and tasks considered essential for safety and relational work are omitted.

In a group interview, several operating room (OR) nurses discussed the impact of their hospital's efforts to reduce the "turnover time" between patients' entry into the OR suite from the pre-operative room and their departure for the recovery room:

First nurse: *Turnover time isn't inherently bad. It's how that time gets used... They can't say that the turnover's over when the nursing hasn't been done. So turnover isn't an inherent evil. It's when they are saying, "Get rid of the nurses"...*

Interviewer: *We can eliminate nursing?*

Second nurse: *There's a movement underfoot...*

First nurse: *...to eliminate that time.*

Third nurse: *Nursing assessment time?*

First nurse: *Nurses going to the pre-op room and pre-opping the patients and taking patients to the recovery room...there's a movement to get rid of them.*

Third nurse: *And replace it with what? We just wait in our rooms and they just bring us a patient?*

First nurse: *That's right.*

Fourth nurse: *And we say goodbye to our patients at the OR door? We don't deliver them to the hands of another nurse to whom we give report?*

First nurse: *That's right. The first time we see them is when they hit the OR door... That's why I say very strongly that they're trying to compress this nursing time.*

Second nurse: *Because they don't see value in it.*

First nurse: *That's right. This [administrative] person said right out to me, he said, "Well, I don't see any value in what you do. You need to be in the operating room itself, getting things ready." He feels that our patient contact is totally unnecessary and he's not happy with it.*

In the OR environment, where the processing of larger numbers of surgical cases per day was identified as the goal, the time during which the nurse meets, assesses, and transfers a patient from the pre-op room to the OR, and similarly to the post-anesthesia recovery unit (PACU) following surgery ("patient turnover time"), was being scrutinized for possible elimination. Yet this time, viewed as superfluous to the "real" work entailed in the actual surgical procedure, was regarded by nurses as essential to preserving the patient's humanity and security in a highly threatening, highly technological atmosphere. This move to speed up patient processing is at odds with the fact that the OR is at particular risk for errors in patient care (Risser et al., 1999, p. 237).

It is worth noting that nurses do not view this process in terms of industrial production — with the patient moving along a sort of surgical conveyor belt as the nurses stand ready to administer therapies to one patient after another. Rather, the patient is delivered "into the hands" of the next nurse, an image suggesting an awareness of the trust placed in nurses by patients and families and the nurses' responsibility to ensure the safe passage of the patient. This process of receiving and transferring the patient includes double-checking of location of surgery, any allergies, and other particulars, and reassuring patients and families that they are in capable and trustworthy hands. This kind of vigilance is impossible if the nurse sees the patients for the first time as they "hit the OR door." In complex organizations made up of strangers, attention to detail and double-checking are essential. Operating room nurses also speak of connecting with families, because it is difficult for family members to say goodbye and turn their vulnerable relative over to strangers. Likewise, in returning the patient from surgery, the nurse obtains crucial information about what has transpired during the procedure.

Nurses also consider the time with the alert patient and family members as vital for ensuring that the planned surgical procedure is the correct one as well as other details. Such last-minute double-checking is essential in a complex system, and the nurses were able to cite many examples where it was crucial to the patient's safety:

First nurse: *It's a frequent occurrence that they want to just rush somebody in — the surgeon or the anesthesiologist. But I tell them, "Just because we're in a hurry, we don't skip nursing." And I make that point, that it is nursing we have to do... So, "I don't care if we are short on time. I don't care if you have to get out of here by 3 o'clock. We don't*

*skip nursing... [There are] some things that I have to check, and it's important."*

*Second nurse: It's a little different when you know the people and you can talk to them one on one. But when you get the message from above [from hospital administration] that you are of little value, it's very demoralizing. I mean, I value the people I work with and I love what I do, but it's so demoralizing to realize that you are still not really valued much at all.*

Time, in this view, is not merely the minutes it takes to perform a particular task multiplied by the number of times it must be performed. Rather, time provides a space for meaningful human interaction to occur. Two pediatric nurses drew attention to this fact when speaking about the importance of developing trust with parents of hospitalized children:

*First nurse: Most of the time families want you to stay, whether you talk or not... If you're just standing there, they're very happy, if you're just there, watching and being with them...you don't even have to talk...you don't have to do anything.*

*Second nurse: Because if you're hyper and uptight, that's a terrible thing to do to them; that gives them a bad message.*

*First nurse: Sometimes you can sense if they want you to take care of the child and they don't want to...if they're so frustrated, overwhelmed, worried [that] they cannot deal with that child. You don't know that unless you stay there and spend some time in a relaxed atmosphere and get the feeling of what's happening in the family.*

Later in the same interview the second nurse added: "I like to quit moving when I get in there [the child's room]... I like to find a chair and sit down and just quit moving... I think it just changes the whole tone...the whole atmosphere, you know, of everybody."

Attending to the "tone" or "atmosphere," intentionally altering it from one of rushed tasks to one that is restful and conducive to healing, is at the heart of nursing's most cherished traditions (Nightingale, 1969). For pediatric nurses, whose practice epitomizes nursing's focus on the whole patient as part of a family and community, such time is especially critical, because they must tailor their practice to the patient's developmental needs and the family's coping resources. Pediatric nurses are concerned not only with the patient's medical problem, but also with preserving and supporting the family through the child's illness. They see therapeutic value in "just being there," bearing witness, offering solace, and attending to a situation in which families are at their most distressed and vulnerable.

People are rarely more vulnerable than during recovery from anesthesia following surgery. At this time patients need both expert management of their physiological needs, such as ensuring that they have sufficient oxygenation, and close attention to their emotional needs, as post-operative patients frequently wake up feeling helpless and confused. When staffing in this setting is reduced to minimum levels, the nursing functions that have to do with physiological management have such priority that care of the patient's vulnerability and personhood, a central precept of nursing practice, may be neglected. Nurses in a PACU commented:

First nurse: *Oftentimes I find it very frustrating. We get so busy that sometimes it's the tasks we have to do to get the patient out of there. Sometimes they just want to hold my hand — that's all they want to do. "I want to hold your hand." I say, "You can have it for 5 minutes and then I have to run off to the next bed." That's what I find very frustrating, that a lot of the care that we can give [is] much more the physical aspect. We don't really have the time to give the spiritual and psychological and emotional care that they really want. Sometimes they just want a closeness to somebody.*

Second nurse: *Right.*

First nurse: *And the way health care is going to be restructured, if the powers that be have their way there will never be an opportunity for that, if they restructure the PACU in a way where other people that are untrained are taking care of our patients and we are supervising eight patients at a time. The patients will never benefit from our expert care. What will happen to us when we're old? Who's going to take care of us? Not people like us.*

"People like us" suggests an ethos of direct-care expertise that this nurse regards as threatened by cost-cutting efforts that move nurses away from the bedside and into roles as the supervisors of less-trained personnel. The distinction between practice and production is evident here. Technicians can be well trained to perform discrete technical tasks, but such narrow training and supervisory delegation of tasks does not take into account good clinical judgement guided by patient needs and vulnerabilities and changes in the patient's condition over time.

Efficiency is the driving force behind much of the health-care restructuring that has taken place. In this context, efficiency is defined in terms of producing more in less time and with fewer resources such as personnel and equipment. In effect, producing more actually means moving consumers (commodities) along a planned trajectory as rapidly and inexpensively as possible. Efficiency may be a worthy goal, but it is

jeopardized when the pace of work is such that practitioners have no time to assess their patients in a meaningful way, weigh priorities, and share their knowledge with patients, families, and one another.

Being responsible for eight patients precludes the ability to follow changes in any one patient over time. Continuous monitoring of a patient's trajectory is replaced by snapshot judgements at particular points in time. To be effective, such a managerial approach to patient care has to include time for assessing patients, talking to patients, and conveying clinical assessments to other nurses.

If nursing care is the provision and monitoring of various technological fixes, and if efficient care is the provision and monitoring of more such technological fixes, whether pharmaceutical, mechanical, or other, for more "consumers" in less time, then what these nurses describe doing (or yearning to do) is not only inefficient but irrelevant. If, in contrast, nursing practice is embedded in human relationships of healing and caring, then what these nurses describe is essential to good practice. Single-minded pursuit of outcomes, without consideration of what nurses and patients are forced to become in the process, undermines the essential good in nursing and medicine (Taylor, 1997). Optimal conditions for healing and care within the family system are possible only when nurses, patients, and family members are treated as persons, not as commodities to be managed as rapidly and inexpensively as possible. The moral ecology of nursing is sustained by institutional structures that allow adequate time for nurses' relational work with patients, families, and colleagues in order to skilfully assess the patient's safety, physiological, and emotional needs and to intervene with appropriate timing and care.

Paradoxically, the industrial production model may lead to reduced efficiency, as nurses lack the time to evaluate and monitor their practice in a cohesive way. Two advanced-practice nurses expressed their frustration with an administrative leadership session they had attended:

*First nurse: We are led by hospital administrators who have to be very concerned about the financial problems, so that's what's constantly being told to us over and over and over again about the constraints and the budget cuts and the this and the that, and it's hard. . . . what we still want to be able to do is maintain quality care. . . . I'm not saying there's no leadership, I'm not saying people don't care, but that's not really what we're hearing, is it?*

*Second nurse: I've heard it from the administrator of our hospital, "Quality patient care is what we want," but it's just. . . that's said over there, but in terms of our nursing department. . . we didn't even talk about [patient care] goals. . . . I mean, we didn't even have time to say, "What is our goal today and what are the priorities?"*

These nurses are describing an “Emperor’s New Clothes” situation in which the administration’s stated goals are at odds with the reality of the practice environment. When nurses are regarded as line workers, care becomes reduced to a piecemeal series of tasks, and the aims of care may be obscured or ill-defined, increasing the potential for misunderstandings, errors, and ethical conflicts between families, patients, payers, and staff.

### ***Erosion of Trust Between Nurses and Patients***

In situations where patients and families do not feel cared for, nurses must do additional work in order to overcome suspicion, resistance, and mistrust (Mechanic, 1996). Trust is jeopardized when temporal or structural constraints preclude relational work. A nurse whose husband had been hospitalized shared insight into some of the basic nursing requirements of patients and families:

First nurse: *The attending [physician] came in and I said to him, “I’m not leaving. I’m not leaving till I know he’s okay, then I’m going to go.” He goes, “It’s fine. It’s fine.” But really, you know, that’s what patients want and family members want. They want to know that you care. If you don’t care, they can’t trust you. And that’s it, you know.*

Second nurse: *Well, you have to care about the patient but you also have to care about the members of the family. Because essentially they are an extension of the patient. They need the information, they need the reassurance, and they need the guidance. They need...to know that you care, that you are a caring person. That trust has to be built...*

First nurse: *...and just let them know that we’re watching and caring, yeah, because the minute you act like you don’t care...*

Third nurse: *...well, the thing is, you lose the trust.*

A healing atmosphere is one in which patients, families, and caregivers trust one another and recognize and commit to a common good. When caregivers are unable to establish trust, their work may become for them a matter of enforcing controls rather than nurturing and healing, resulting in a loss of their identity as healers. Central to the practice of nursing is the poorly articulated and poorly understood social function of meeting the other and bearing witness to his or her plight and concerns. It is in this relational arena that trust and safety thrive and patients are assured of not being reduced to a number.

When clinicians feel rushed and harried, their ability to engage with patients and families is impaired, resulting in a disruption of their self-identity as healers. They express moral outrage on behalf of their patients and themselves. This reflects not merely a concern with niceties but an

assault on nurses' identity as caring practitioners. An OR nurse described the atmosphere that results from staff cutbacks:

*The [operating] room's still bloody and dirty. And so, if nobody's there to clean up, then we're [nurses are] expected to grab a mop and mop the floor, and wash the walls and wash the bed. This is what happened to us last week. There was a patient who was very ill and it was a big messy room and... I had to grab a mop and start sweeping and mopping away. Our next patient was a young man who needed a double valve [replacement] and he was absolutely terrified. I met him in the pre-op area. His whole family was terrified. They were all just very emotionally uptight. And the anesthesiologist rolled this guy back to the room that's still covered with blood and parks him next to the two big trash cans with the big containers of blood and guts and trash and says, "Are you ready? Can we bring him in?" And he's right there in the door of the operating room and I'm swinging a mop. And, you know, to me it was the worst thing that I've seen happen to somebody in a long time, and I just — it's like the patient is not significant to them, I'm not significant to them, and all they want to do is roll as many bodies in and out of that room as they can. And that's terrible! That's terrible what that man went through. He was scared to death... I think that our profession is being eroded away by incidents like this and attitudes like this, and cutting way back on the staffing and trying to cut corners at all costs. You know, that to me is very upsetting because I feel my professional practice is being eroded as well.*

The ideal of patient as consumer that is foundational to free-market ideologies in health care breaks down under such circumstances (Malone, 1998). This patient, partially anesthetized for surgery to correct a life-threatening problem, is utterly vulnerable; he is not a consumer who can pick and choose among options. Likewise, the ideal of nurse as manager of a "service line" breaks down as her efforts to ensure a safe and humane atmosphere are disregarded. This example also illustrates the limitations of construing "medical errors" as discrete sentinel events or critical incidents. A breakdown in civility and lack of concern for the patient's integrity constitute bad practice that could have harmful effects on the patient's well-being. An ethos of civility and concern that *discloses* the patient's basic humanity creates social practices of "etiquette" that determine the proper ethical comportment in a particular situation (Day & Benner, 2002). In this case, etiquette, ethical comportment, and an ethics of civility and concern broke down, causing the nurse to become angry and disgusted (see Nussbaum, 2001). Such incidents are likely to be detected or disclosed only by practitioners whose intention is to do no harm and to show compassion, thus fulfilling their fiduciary responsibility to the patient (Sharpe & Faden, 1998).



Such a health-care environment devalues the humanity of both patient and nurse in favour of a system in which actual service is supplanted by the rapidity with which it can be delivered. Nurses are put in the awkward position of having to coach family members to be vigilant and to become involved in the care of their hospitalized loved ones because of staff shortages:

*Because we are number one witnesses to just how the retrenchment has affected my institution, I am acutely aware that patients need someone with them to help them while they're in the hospital, whereas before I did not feel that way; I did not see the shortage of...nurses.*

This participant and others related instances of members of their own immediate family being hospitalized or too hastily discharged and needing their nursing skills and vigilance. A nurse described the advice she now gave to patients' family members:

*I try and educate my families about how they need to stay with their family member to protect them. I don't quite say that, but I will say to the wife that's coming to visit the husband, "Are you staying the night tonight?" And she'll say, "Well, I'm not sure." I'll say, "I think you should stay. I would stay if I were you." ...I would not think of leaving my own family member, even my husband.*

The moral ecology of nursing requires a trusting relationship so that patient and family vulnerabilities are identified and protected. Trust and the relationships necessary to build and maintain trustworthiness in health care are central to curing, healing, and palliative treatment. Caring practices such as bearing witness, developing trust, getting to know a patient, and being present point to the relational work that is central to the art of healing (Benner et al., 1999; Benner & Wrubel, 1989). Yet this is the very work that is most vulnerable to cost-cutting strategies; it does not fare well in proving its worth in instrumental ways. In the long run, however, it may be more economical to preserve those professional practices that sustain trust than to try to restore trust and good will once they have been supplanted by suspicion and doubt.

### ***Loss of Identity: Patients and Nurses as Commodities***

The managerial practice of making physicians and nurses accountable for patient populations rather than individual patients represents a major shift in the moral landscape (Shultz, 1999). For example, while nurses cite the positive effects of managed care for getting premature infants weaned from technological supports and sent home more quickly, earlier discharge for well babies is based upon an acceptance of the risk that some babies will end up being readmitted. The current emphasis on

acceptable levels of complications within a patient population — versus a fiduciary concern for the individual and the family, whose losses may be considerable and irreversible — is a major shift in the ethos of practice. One group of nurses spoke about the early discharge of well babies:

First nurse: *[There are problems with] sending babies home too fast.*

Second nurse: *You know, they...go home at 12 hours or 24 hours, and they haven't — the milk isn't in, they haven't latched on, they don't know how to breastfeed, they come back in and the poor baby...*

First nurse: *...they become dehydrated with hyperbilirubin...*

Second nurse: *...hyperbilirubinemic and dehydrated...*

Third nurse: *...and the mother feels completely inadequate.*

First nurse: *It's devastating for the mother.*

Third nurse: *She'll stop breastfeeding. It's a horrible experience. They feel failures as parents... You know, they have no one — they don't have extended families [to] teach them to breastfeed. By the time they get back [to the hospital] the baby is so dehydrated and so listless, because its bilirubin is so high, that breastfeeding is just not going to happen... And then the mother's milk supply dwindles, and it's — it's...oh, it's terrible, it's awful!*

First nurse: *When you look at the overall number of well babies who go home...it's a small percentage that gets readmitted and so they're saying it's not economically feasible to hang on to everybody for 24 hours or 48 hours or whatever. And, I mean, that's true, it is a small number, but it's still the ones that slip through the cracks.*

Nurses acknowledge the fact that some patients and families benefit from streamlined care and early discharge. However, streamlining entails a shifting of costs to parents and family members, who may not be prepared to provide the level of care that is required. The moral boundaries of care and responsibility have been redrawn. The policy of standardized discharge practices is drawn up with “acceptable risks” for patient populations in mind. However, nurses do not see their work with individual babies in terms of “acceptable risks”; when babies are readmitted, nurses feel the moral burden of their failure to avert harm. Additionally, parental responsibility for medical monitoring is considerably greater and more daunting than the usual parental responsibility to protect and nurture. It is little wonder that many parents feel ill-prepared.

The moral ecology of responsible nursing practice is radically altered when insurance criteria for discharge take precedence over professional

judgement and must be overridden or negotiated by professional arguments in favour of additional hospital services. Interestingly, the nurses identified the “well babies” and their parents as at greater risk from the ever shorter hospital stays than the babies in neonatal intensive care, whom the system recognizes as at risk. In the well-baby group, there is little or no indication of which well mothers and infants will have difficulty with breastfeeding, so there is no clinical basis for altering the insurance guidelines for early discharge. Sending infants and mothers home before the mother’s milk comes in precludes the breastfeeding instruction formerly provided by nurses.

It will be years before the liability costs and the relative costs of re-admission are weighed against the new early-discharge practices. But the costs must also be weighed against the question of whether any infant and mother should be discharged before safe feeding patterns have been established. The potential for harm caused by failed early feeding for a certain percentage of babies may be an acceptable economic risk but an unacceptable human risk.

The shift to a population-based model is accompanied by a shift towards institutional accountability to insurers and purchasers of insurance. This latter shift was evident in the pressure not to admit day-surgery patients to the ICU because increased complications, and thus costs, would mar the hospital’s and the physician’s record with payers. For example, one nurse was observed negotiating for an ICU bed for a pediatric patient who was in respiratory distress and would likely need continued ventilatory support. The decision was postponed as long as possible, the nurse explained, in order to avoid an “unnecessary” admission and elevated complication rates for the hospital and the physician. Ultimately, the patient was admitted to the ICU, but against the gradient serving to protect the performance statistics of the hospital and the physician group. The addition of this institutional and group focus to the existing family and patient focus creates a new layer of accountability and indicates a need to consider new models of accountability (Malone & Luft, 2002).

The ethos of saving money to increase profits in a for-profit system is very different from that of cutting costs to improve distributive justice. The Kantian ethic of treating people as ends in themselves, rather than as means to some other end, is violated when cost savings do not support improved services for more people but, rather, support increased profits for stockholders (Weisskopf, 1977). This ethos sacrifices clinicians’ fiduciary trust with patients for “acceptable” levels of complications and risks within patient populations. At the individual level, complications add to suffering and even death; the risk is unacceptable (Shultz, 1999). In hospital environments that have been redesigned for the “efficient”

provision of various “service lines,” based on an industrial production model, the patient is viewed not as a consumer but as a commodity to be produced and traded. In this model, the least expensive patients are the most valued patients. Contrary to this ethic of processing patients (commodities) in order to maximize shareholders’ profits, the moral ecology of nursing is contingent upon institutional values that situate the patient’s and nurse’s humanity at the centre.

### ***Health Care in the Marketplace***

Health-care restructuring is often justified on the grounds that it limits the overuse of expensive services. The claim is that health care, as a business, can be run more efficiently by trimming staff, reducing waste, and using other measures designed to minimize per-patient costs. Protection of patients from unscrupulous acts in a climate of cost-cutting relies heavily upon the patients themselves, as consumers who will shop elsewhere if services are unsatisfactory, and upon professional ethics and the ability of clinicians to uphold them. These means, however, are constrained by the interests of payers, insurers, and groups of physicians who share risks and profits. In such an environment it is difficult for patients and individual nurses and physicians to exert control over the style and quality of practice:

First nurse: *[I] need to touch base with the fact that I’m a human being...it’s not just hemostats and scalpels.*

Second nurse: *As we get caught up in the busy day-to-day, short length of stay, people moving in and out, it’s almost Greyhound. It’s a Greyhound depot...the basics get lost.*

The rhetoric of this system redesign — that the changes promote better care at lower cost — is revealed as a fraud by the nurses’ expression of frustration at their inability to provide what they regard as basic nursing care. In fact, such system redesign creates temporal and other barriers to the provision of safe care. The aim becomes not care but the rapid processing of people, compelling clinicians to struggle on a daily basis to convince themselves that they are doing good. Such circumstances undermine the basic moral ecology of good nursing practice. In situations of cost-driven urgency, nurses’ concern for patients on a human level can actually become a problem insofar as it requires time and resources that are not forthcoming. Confronted with this situation, clinicians may resort to subverting the system in order to preserve fragments of their identity as healers, as suggested by a critical-care nurse:

*I guess more or less for myself as a nurse, I basically have expectations... I make sure that patients are always kept cleaned up. I make sure they’re*

*okay. It's kind of hard [in ICU] because most of my patients are intubated so we don't have that rapport, but we do have the rapport with families... I was a patient myself for two and a half weeks, and it wasn't that bad but it changes everything, you know. Like sometimes you have patients call you every 5 minutes and you're, like, what does she have to call me every 5 minutes for? [embarrassed laugh] And then I realize that, being on bed rest for two and a half weeks, you have no concept of time, 24 hours just keep going for days and days and days... For me, I have to always straighten up my patients' sheets, or change them, make sure the patient's comfortable, because I was lying in bed for two and a half weeks and that bed can be really uncomfortable, where you get body aches and you're not even doing anything. And that's a big thing for me. I get upset when they're telling us to cut back on linen and [not to] change the sheets unless they're soiled. I mean, that bothers me a lot, but I still manage to do it. If I have to sneak them into [the] room I still do it.*

Care becomes something to be surreptitiously snatched, a covert activity. Human caring for those who are suffering becomes something for which clinicians no longer have time:

*First nurse: I mean, [second nurse] and I help support each other that it's okay to stay in that role, you know, and that's good. "This is what this is all about," and "Yes, what I am identifying is important." What I have been doing is important even though nobody else — we feel like nobody else really is doing that or sees it [direct patient care and comfort measures] as important.*

*Second nurse: How to keep the patient care as the priority through all of this other extraneous bombardment — things that just weren't there [before].*

*Third nurse: I try to look at the very big picture, and I just remind myself from time to time that managed care is not only inadequate, it's probably a deliberate fraud in that it's an attempt to further privatize care under the guise of reform, and in that it specifically and deliberately ignores the uninsured. What I say to myself is...managed care is to national health what the Depression was to social security.*

### **Conclusion: A Moral Ecology of Care**

In this study, critical-care nurses told stories about their practice that revealed strains in sustaining an ethic of good nursing in the face of the economic restructuring of health care in the United States. For example, despite increased patient acuity, downsizing has resulted in greater utilization of less-trained per diem and float nurses, requiring written standards

to establish minimum safety requirements for a pool of inconsistent staff, in place of a team of nurses whose cohesiveness promoted nursing excellence. The press for efficiency has resulted in system restructuring that allows less time for nursing care and assumes an indifferent if not dismissive stance towards the relational practices in which nurses engage to ensure the security, well-being, and humanity of their patients. An institutional environment in which the trust of patients and families is compromised puts nurses in the awkward position of having to coach families to be vigilant. Redesigned systems that view nursing care through the lens of an industrial production model, wherein patients are treated as consumers at best and as commodities at worst, have compelled nurses to act surreptitiously to sustain caring practices that ensure patients and families a safe and humane passage.

As members of an institutionally based profession, nurses rely on institutional structures to support the caring functions that constitute good nursing practice. Besides the physical dimensions, the temporal and moral dimensions of institutions can increase or decrease the likelihood that a community of practitioners, organized around common goals, will adopt the standards and visions of good practice and pass them on to new generations of practitioners. This moral ecology, or the interaction between nurses and the institutional environments on which they rely, directly affects nursing practice and the well-being of patients and families. Discussions of organizational ethics should be broadened to address the issue of whether institutional resources and structures enhance or constrain patient care as they impact on nursing and medical practice.

Medicine and nursing are founded on a vision of healing and responsiveness to suffering. Aristotle was the first to see a distinction between the production of things and the practice of an art or science, which requires character, skill, responsiveness, and relationship. Survival of an institutionally based practice like nursing requires an ecology wherein caring and compassion are the *raison d'être* of the practice. In such an ecology, practitioners and patients have the time to integrate experience; pass on experiential learning to novice practitioners; develop creative ways of effecting change; sustain a sense of trust and connection on a human level; and grow and move forward in innovative, responsive ways (Benner et al., 1996, 1999). Alasdair MacIntyre has written on the value of institutionalizing practices so that their visions can be fulfilled:

Lack of justice, lack of truthfulness, lack of courage, lack of relevant intellectual virtues — these corrupt traditions, just as they do those institutions and practices which derive their life from the traditions of which they are the contemporary embodiments. To recognize this is of course also to recognize the existence of an additional virtue, one whose impor-

tance is perhaps most obvious when it is least present, the virtue of having an adequate sense of the traditions to which one belongs or which confront one. This virtue is not to be confused with any form of conservative antiquarianism; I am not praising those who choose the conventional conservative role of *laudator temporis acti*. It is rather the case that an adequate sense of tradition manifests itself in a grasp of those future possibilities which the past has made available to the present. Living traditions, just because they continue a not-yet-completed narrative, confront a future whose determinate and determinable character, so far as it possesses any, derives from the past. (MacIntyre, 1981, p. 207)

What kinds of caring traditions do we as a society want to sustain for ourselves and our families? The experiences of these nurses warn us that the moral ecology of caring practice is in jeopardy. Both nursing and medicine, as living traditions and as professions, must shoulder part of the responsibility for curtailing the escalation in health-care costs. However, in order to do so while providing morally grounded care, they must act within systems and institutions that instantiate and support a healthy ecology of practice, not merely an assembly line of tasks.

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