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Members of the nursing profession, for a variety of reasons including the nature of the profession but also economic exploitation and sexism,[1] have been "caught in the middle." On the one hand, for example, the nurse is hired to carry out the directives of the physician and to support the policy of the hospital administration. The system cannot function as presently constituted without such co-operation and support in carrying out the decisions and policies of those higher up in the hierarchy. Yet, on the other hand, the nurse is legally and morally accountable for her or his judgments exercised and actions taken. "Neither physician's prescriptions nor the employing agency's policies relieve the nurse of ethical or legal accountability for actions taken and judgments made."[2]

A common predicament of nurses is expressed in the April issue of *Nursing 78* by a nurse at a West Coast university hospital. She says:

> Our biggest problem right now is that our nursing leadership at the administrative level is completely impotent. They have no voting rights on any committee that has direct control over the hospital and/or nursing. Worse, the acting director and her associate have no idea of taking any power into their own hands, where it rightfully belongs. They ask permission to improve staffing ratios, by increasing or closing beds, and when they're turned down, say to us 'Sorry girls! Work doubles' . . .[3]

The overwork and understaffing not only make working conditions less than desirable for the nurse, they clearly endanger patients. When, for example, one registered nurse and an aide must try to care for thirty to thirty-six patients who have just undergone surgery, the situation is very dangerous and health care cannot be delivered in accordance with acceptable standards.

We can all sympathize with the nurse who wrote the following:

> I am supposed to be responsible for the control and safety of techniques used in the operating theatre. I have spent many hours teaching the technicians and the aides the routines necessary for maintaining aseptic conditions during surgery. They have learned to prepare materials and to maintain an adequate supply for all needs. They have learned to handle supplies with good technique.
>
> I find it is extremely difficult to have these appropriate routines carried out constantly by employees with little theoretical background or understanding. The surgeons are frequently breaking techniques and respond in a belligerent manner when breaks in technique are brought to their attention. I find a reminder of techniques often brings a determined response to ignore the reminder and proceed with surgery. For a male surgeon to be questioned by a female nurse is a serious breach of respect to them.
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> One day a surgeon wore the same gown for two successive operations even though there were other gowns available. I quietly called this to his attention,

but I had no authority which really allowed me to control his behavior for the good of the patient. In this situation even the hospital administrator was of no help to me.[4]

This nurse is responsible for the control and safety of techniques used in the operating rooms. The conditions over which she is responsible have fallen below acceptable standards. Although she has done her best, the assigned task has not been accomplished. The patients who have a right to expect, and have paid for, a safe and aseptic operating room have been let down.

Nursing is the largest group of health care professionals within the vast health care delivery system -- a system that, despite some dramatic achievements, is increasingly under attack as dehumanizing, exploitative, and cost-ineffective. Despite the seeming powerlessness of any individual nurse, taken collectively nursing more than any other health care profession is a necessary component in the emergence of the present health care delivery system. The present system could not have developed without nursing. If all nurses were to walk out tomorrow, the system would collapse. This cannot be said for any other group of health care professionals including physicians. Hence, if the health care delivery system is substandard (as I believe it is), the nurse is not merely a victim of the system (along with the rest of us), but she or he is also an accomplice. As an accomplice she shares responsibility for the system's deficiencies. The nurse's plight is by no means unique. The paradoxical plight of the nurse of being both powerless and powerful, responsible yet not responsible, is a plight in which we almost all find ourselves in some aspects of our lives.

One way to try to make sense of these paradoxical situations -- the way to be explored in this essay -- is to introduce the notion of collective responsibility. Two dramatic and widely discussed illustrations of this are the prosecution's case against certain middle-level Nazis after World War II and the defense's case for First Lieutenant William Calley charged with murder at MyLai.

In the prosecution case, blame for the actions of certain individual members of the collective is ascribed to all members. Karl Jaspers expressed this view when he said: "Every German is made to share the blame for the crimes committed in the name of the Reich . . . inasmuch as we let such a regime arise among us."[5] In condemning every German, Jaspers is not merely blaming each German for his active or passive tolerance of the Nazis. He is saying that "the world of German ideas," "German thought," and "national tradition" are to blame. Collective responsibility is used as a net from which no member of the collective can escape.

In the defense case, the individual whose behavior has fallen below the acceptable standard is shielded from the full weight of blame, because the weight is shifted to the collective. It is the collective, the system, that must bear the brunt of the burden rather than the individual. In the Calley case it was claimed that Americans as a group failed to perform as they could have been expected.

In a recent survey of nurses' attitudes[6] this defense strategy was tacitly used. It was reported that, although nurses saw themselves as performing well given the work conditions, they "felt they ought somehow to deliver even when the system won't let them." The writers of the report indicate that this blame is misplaced ("not deserved"). Although performing below the acceptable standard, they were not to be blamed because

as individuals each was doing the best possible for her in the situation. The system itself was to be blamed.

If the blame appropriately ascribed in a situation is no greater than the sum of all the ascriptions of blame to the individuals, we do not have a case of collective responsibility except in a weak (distributive) sense. By collective responsibility in the strong (non-distributive) sense -- as the term is to be used in this essay -- we mean that the responsibility of the group is not equivalent to that of the individuals. That is, the whole is not equal to the sum of its parts.

It is incontrovertible that we do ascribe responsibility to collectives in this strong sense. To use an example of D.E. Cooper[7], if we say that the local tennis club is responsible for its closure we don't necessarily or usually mean that the officers of the club or any particular members are responsible for its closure. If you were to question the speaker he may be unwilling to blame any particular individuals or the officers of the club. It is not that any person failed to do what was expected of him. Yet something was missing. "It was just a bad club as a whole."[8] From the claim that the local tennis club is responsible for its closure no statements about particular individuals follow. "This is so," as Cooper says, "because the existence of a collective is compatible with a varying membership. No determinate set of individuals is necessary for the existence of a collective."[9]

As R.S. Downie has argued, " . . . to provide an adequate description of the actions, purposes, and responsibilities of a certain range of collectives, such as governments, armies, colleges, incorporated business firms, etc., we must make use of concepts which logically cannot be analyzed in individualistic terms."[10] The reductionists who deny this have the principle of parsimony on their side, but little else. Although the reductionist says the ascriptions of collective responsibility could be reduced to statements about individuals, he does not do it. These reductionistic attempts suffer from the same problems and deserve the same fate as the discredited reductionist programs in theory of knowledge and philosophy of science.

The question to ask then is what set of conditions must obtain in order properly to ascribe non-distributive, collective blame or responsibility. The conditions advanced by Cooper in his essay "Responsibility and the 'System' " are sufficiently accurate and refined for purposes of this essay. These conditions are:

1. Members of a group perform undesirable acts.

2. Their performing these acts is partly explained by their acting in accordance with the "way of life" of the group (i.e. the rules, mores, customs, etc. of the group).

3. These characteristics of the group's "way of life" are below standards we might reasonably expect the group to meet.

4. It is not necessarily the case that members of the group, in performing the acts, are falling below standards we can reasonably expect individuals to meet.[11]

A few comments about these conditions are in order. Clearly we do not *hold* an individual or group responsible -- that is, following its etymology: having liability to answer to a *charge* -- if undesirable acts have not been performed. When no undesirable acts occur, the

question of blame or responsibility in the sense of liability does not arise. Hence we see the need for condition 1.

The second condition is not strictly necessary. It does seem, as Virginia Held has argued,[12] that when special conditions obtain even a random collection of individuals can be held responsible (a claim denied by condition 2). However, for present purposes -- consideration of collective responsibility of members of a profession -- this stronger claim need not be defended. The most plausible cases for ascribing collective responsibility are those cases in which the group has distinctive characteristics, has a sense of solidarity and cohesion (for example, feels "vicarious pride and shame"[13]) and members identify themselves as members of the group (for example, "Who are you?" "I am a nurse.") and some of these group feelings or characteristics are appealed to in explaining the acts in question. For example, if the citizens of Syldavia can be characterized as being rather hostile and distrustful of foreigners, and their customs, laws, and policies reflect this, then, when (say) some border guards -- in overzealously carrying out the Syldavian policy -- kill some visiting dignitaries, we blame not only the border guards but also the Syldavians. In contrast, if these border guards steal from the visiting dignitaries but in accounting for this behavior we would not be inclined to appeal to any larger group feelings or characteristics, we definitely would not wish to ascribe collective blame.

We have seen above in the variety of cases discussed that it is when a collective fails to live up to what can reasonably be expected of it -- i.e., it falls below an acceptable standard -- that it can incur collective blame. Hence we see the need for condition 3.

Condition 4 is necessary because the standards applied to groups may be different from those applied to individuals. For example, we may feel that the nurse (in the case cited above) who was charged with responsibility for the control and safety of techniques used in the operating rooms adequately met her obligations. She did not fall below standards we can reasonably expect an individual to meet. After all, as Joel Feinberg has argued, "no individual person can be blamed for not being a hero or a saint." Yet, as Feinberg goes on to say, "a whole people can be blamed for not producing a hero when the times require it, especially when the failure can be charged to some discernible element in the group's 'way of life' that militates against heroism."[14] Although Feinberg was not talking about this case or collective responsibility of the nursing profession (he was talking about a Jesse James train robbery case), his remarks are especially apt for this case and many other situations within the nursing profession.

One can readily see that conditions outlined for properly ascribing non-distributive collective responsibility obtain in many situations within professions. Professions more than most other collectives are bound together by common aspirations, values, methodologies and training. In too many cases, they also have similar socio-economic backgrounds and are of the same sex and ethnic group. As we have seen, the more cohesive the group, the less problematic the ascription of collective responsibility. The fact that professions such as nursing promulgate codes of ethics or standards of behavior toward which they expect members to strive, provides a clear criterion for judging whether the actual practices of the profession fall below standards to which we can reasonably hold the group.

In addition to meeting these formal criteria for ascribing collective responsibility, there are several other reasons unique to professions for ascribing collective responsibility in certain situations.

A. There are several ways by which one becomes responsible. One can be *saddled* with it by circumstances, one can have responsibility *assigned* to one, or one can deliberately *assume* responsibility.[15] Typically a profession is chosen. In choosing the profession, one *assumes* the responsibility concomitant with being a professional. One chooses to adopt the values, methodology, and "way of life" of the profession. Such choice is much less prominent with most other basic group affiliations. One does not choose family membership, region of birth, usually not citizenship, and often not military service. Once in the profession, of course, as one goes about his job he will also sometimes be saddled with responsibility by circumstances and be assigned responsibility. But these assignments are all within the context of choice to assume professional responsibility. This choice to assume professional responsibility provides the backdrop for all his professional activities. Hence, as a professional, more than most other group affiliations, one sees oneself as a member of the group and has -- with eyes open -- chosen the identification.

B. Nurses (as is, of course, also the case in several other professions) have been vested by the state with the power to regulate and control nursing practice. This collective power or right -- given exclusively to the profession -- has concomitant with it a collective responsibility or duty to see to it that acceptable standards are maintained. Since it is possible that each individual nurse including officers of the American Nursing Association is meeting acceptable standards in her or his own assignments and yet the group's "way of life" must be characterized as below an acceptable standard, appeal to collective responsibility is one of the tools the public has at its disposal to try to insure adequate nursing and general health care. Obviously in these cases (when no individual has failed to meet her or his legal obligation) the public does not have recourse to lawsuits against individuals.

C. Supposedly as a means to protect the public, the licensing statutes of the states allow only those who have passed certain requirements set down by the state to practice nursing. One result of this is that the profession which is by law also self-regulatory becomes a protected monopoly. If a person is going to receive nursing care, this care must be provided by a member of the profession. If nursing care is to be upgraded, it must be from within with at most prodding from without. Quite clearly one of the most effective tools for such prodding is that of demonstrating collective responsibility, a resonsibility that goes beyond the sum of each individual's responsibility.

From the discussion thus far, it is evident that the appeal to collective responsibility when some substandard behavior or undesirable acts have occurred is a two-edged sword. It can be used to show that, despite undesirable performances or actions or conditions in a collective, a particular member of the collective is not individually responsible. However, it can also be used to show that, despite the fact that the behavior of individuals does not fall below standards we can reasonably require individuals to meet (given that we cannot *demand* that an individual be a hero), the group's conduct is below standards we can reasonably expect the group to meet. One of the reasons the weapon of collective responsibility looks suspect in the widely discussed World War II prosecution and Vietnam conflict defense cases is that only one edge of the sword is used while the other edge is conveniently ignored.

If conditions for properly ascribing collective responsibility are satisfied, to the extent that the individual is exonerated, the group is indicted. To the degree the individual *qua* individual is indicted, the group is exonerated. Either way the individual group member bears responsibility. For any member of a collective but especially (for reasons cited

above) a professional, it is not enough just to know that one has done all that could be expected of him or her strictly as an individual. The arm of responsibility for a professional has a longer reach than that of the individual.

Specific situations within the nursing profession illustrate the two edges of the sword of collective responsibility. These situations should be seen within the context of the rapid evolution of the nursing profession in recent years. In recent years there has been considerable effort both within and outside the profession (e.g. the medical profession) to upgrade the requirements for licensure. These efforts have borne results. The scope of the professional nurse has expanded greatly as exemplified by medical assistant programs and the use of nurses as paramedical practitioners to relieve the shortage of medical doctors in certain areas. The history of the struggle first to adopt a code of ethics for American nurses and then to revise it reflects this evolution. Tentative codes were presented in the 20's, 30's and 40's. These efforts were met by opposition from those who feared the professionalization of nursing. A striking instance of this is the advice given by a physician to one of the earliest advocates of a code of ethics for American nurses: "Be good women but do not have a code of ethics."[16] It was not until 1950 that a code of ethics was adopted.

The code has been changed several times since then, the most recent being in 1976. Two of the most interesting changes from our vantage point have been the following: Earlier versions stated that the nurse had an obligation to carry out physician's orders. The 1968 and 1976 versions of the code stress instead the nurse's obligation to the patient (called client in the 1976 version). The physician just mentioned who advised against having a code may have foreseen this development! Whereas earlier versions of the code point to an obligation to sustain confidence in associates, this has been replaced by the obligation to protect the patient from incompetent, unethical, or illegal practice from any quarter.[17]

With this background one can see why it is especially interesting to look at the nursing profession when speaking of collective responsibility in the professions. The fundamental issue in the on-going struggle to upgrade the profession -- reflected in the code changes -- has been that of accountability, the willingness to make decisions and accept responsibility for these decisions. The crucial question in the attempt to upgrade the profession is that of the interface of individual and collective responsibility.

The author of an article in the *Quarterly Record of the Massachusetts General Hospital Nurses Alumnae Association* wrote about "blame avoidance" behavior in nurses. As explained, blame avoidance behavior is exhibited when the nurse says such things as "I did this because the supervisor told me to do it," or "the doctor ordered it," or "the hospital rules demanded it." The author maintains that accountability requires that the nurse can say, "I did this because in my best judgment it is what the patient needed."[18] Setting aside the many good qualities common to nurses, blame avoidance behavior does seem to be one of the more prevalent, endemic faults of the nursing profession. As we have seen, a concerted effort by many within the profession has made inroads on this "way of life" of the profession.

These efforts have been made without explicit appeal to the concept of collective responsibility. As a result, judgment in cases of blame avoidance and other unacceptable or undesirable behavior has tended either to be too harsh or too lenient. That is, either (A) one judges that the individual nurse caught in the middle and in difficult circumstances has done all one can reasonably expect her to do. After all, we can not expect or demand that she be a hero or a saint. Hence, the nurse is exonerated. Yet the unacceptable practice or condition continues unabated. Or (B) one focuses on professional responsibility and the

fact that, if some individuals do not stand up against substandard practices -- no matter what the odds of thereby improving the situation and no matter at what price to the individual -- these practices likely will not be stopped. From this perspective the individual nurse who fails to do all within her power -- including actions that will likely cost her her position -- to insure the best care possible for patients in her care is judged to be a moral coward.

For example, in the case of the nurse charged with responsibility for maintaining a safe and aseptic operating room, without appeal to the concept of collective responsibility we are likely to say either: i) that she has done all we can require of her -- (She has asked the surgeon to comply. She does not have the authority or status to demand compliance to proper procedures. The lack of compliance quite properly was followed by a report to the hospital administration); or ii) that she has not done all we can require of her -- (She cannot allow dangerous violations of operating room aseptic standards to take place. In doing so, she is failing to carry out her assignment and is allowing the patient's life to be placed in jeopardy. She should not be cowed by the surgeon's arrogance and sexism. Even at the risk of losing her job, she cannot allow the operation to take place in these conditions).

The problem is that i) is too lenient a judgment and ii) is too harsh. We cannot require the nurse *qua* individual to do more than she has done. But the nurse *qua* nurse shares blame with her colleagues in such cases despite the much greater blame which must be placed on the surgeon violating reasonable requirements. The lack of aggressive advocacy for the patient's welfare, the willingness to be dominated by the (usually male) physician or surgeon -- unfortunate even if understandable "ways of life" of the nursing profession -- which partially explain this nurse's behavior are below the standard we can rightfully expect the group authorized to provide nursing services to meet. Appeal to collective responsibility yields a judgment neither too harsh nor too lenient.

This judgment conforms to the moral intuitions of the nurses surveyed who were mentioned earlier. Despite a feeling that as individuals they were doing all that could reasonably be required of them in their circumstances, they still felt dissatisfied with their performance. As nurses they felt blame for falling short of the mark set for the profession.

This dissatisfaction, when seen in the light of collective responsibility, can be turned to positive use. The nurse who has done all she is required to do as an individual need not suffer debilitating guilt. Guilt, in such cases, is misplaced. Her individual actions do not warrant guilt. And, in contrast to non-distributive collective responsibility, there is no non-distributive collective guilt. "Guilt," as Feinberg has said, "consists in the intentional transgression of a prohibition." ". . . there can be no such thing as vicarious guilt."[19] However, although rightfully free of guilt, she cannot be complacent. She is a member of a group that stands judged (i.e. is liable) and must, with her colleagues, take appropriate steps to alleviate the undesirable conditions. It is not enough for a professional to do all that is required of her or him as an individual. Having freely accepted the privileges and benefits of the profession, one's responsibility in the areas of professional competence are greater than would be those of an equally skilled and knowledgeable individual who was not a member of the profession.

In order to meet this larger responsibility, as the American Nursing Association has recognized, "there should be an established mechanism for the reporting and handling of incompetent, unethical, or illegal practice within the employment setting so that such reporting can go through official channels and be done without fear of reprisal. The nurse

should be knowledgeable about the mechanism and be prepared to utilize it if necessary."[20]

Paradoxically if such machinery which collective responsibility requires were put in place, individual accountability would increase and the need to appeal to collective responsibility would decrease. If reporting incompetent, unethical, or illegal conduct could be done effectively through official channels and done without fear of reprisal, such reporting -- which under more dangerous and less effective circumstances is not required -- would be morally required of the individual. Hence, it may be that a profession should strive to organize itself and regulate itself to such a degree that the conditions for proper ascription of collective responsibility do not arise. But this is not the situation within the nursing profession at the present. Therefore, I conclude that the notion of collective responsibility is a timely weapon of considerable force for those who are working toward upgrading the nursing profession and the health care delivery system.

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NOTES

[1]Cf. Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse* (New York: Teachers College Press, 1976) for a discussion of economic exploitation and sexism which have plagued the nursing profession.

[2]"Code for Nurses with Interpretive Statements" (Kansas City, Mo.: American Nurses' Association, 1976), p. 10.

[3]Marjorie A. Godfrey, "Job Satisfaction -- Or Should That Be Dissatisfaction? How Nurses Feel About Nursing," Part I, *Nursing 78* (April 1978), pp. 101-02.

[4]Barbara L. Tate, ed., *The Nurse's Dilemma* (New York: American Journal of Nursing Company, 1977), pp. 47-48.

[5]Quoted by D. E. Cooper, "Responsibility and the 'System,' " in Peter French, ed., *Individual and Collective Responsibility* (Cambridge, Mass.: Schenkman Publishing Co., 1972), p. 86.

[6]Godfrey, *ibid.*, Part II, *Nursing 78* (May 1978), p. 110.

[7]D. E. Cooper, "Collective Responsibility," *Philosophy*, vol. XLIII, no. 165 (July 1968), pp. 260-62.

[8]*Ibid.*, p. 262.

[9]*Ibid.*, p. 260.

[10]R. S. Downie, "Responsibility and Social Roles," in French, *op. cit.*, p. 69.

[11]"Responsibility and the 'System,' " in French, *op. cit.*, pp. 90-91.

[12]Virginia Held, "Can a Random Collection of Individuals Be Morally Responsible? " *The Journal of Philosophy*, vol. LXVII, no. 14 (July 23, 1970), pp. 471-81.

[13]Joel Feinberg, "Collective Responsibility," *The Journal of Philosophy*, vol. LXV, no. 21 (Nov. 7, 1968), p. 677.

[14]*Ibid.*, p. 687.

[15]Kurt Baier, "Guilt and Responsibility," in French, *op. cit.*, p. 52.

[16]Lavinia L. Dock, *A History of Nursing*, vol. III (New York:G. P. Putnam's Sons, 1912), p. 129.

[17]Cf. Kathleen M. Sward, "An Historical Perspective," in *Perspectives on the Code for Nurses* (Kansas City, Mo.: American Nurses' Association, 1978) for a discussion of these and other changes in the versions of the code.

[18]Quoted by Barbara Durand, "A Nursing Practice Perspective," in *Perspectives on the Code for Nurses* (Kansas City, Mo.: American Nurses' Association, 1978), p. 19.

[19]Feinberg, *ibid.*, p. 676.

[20]Sward, *ibid.*, p. 8.