CHAPTER 2

Introduction to Bioethics and Ethical Decision Making

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The tiniest hair casts a shadow.

—**Johann Wolfgang von Goethe**, German poet and dramatist (1749–1832)

OBJECTIVES

After reading this chapter, the reader should be able to do the following:

1. Discuss the history of bioethics.
2. Use the approach of ethical principlism in nursing practice.
3. Analyze bioethical issues in practice and from media.
4. Identify criteria that define an ethical dilemma.
5. Consider how critical thinking is used in ethical nursing practice.
6. Use selected models of reflection and decision making in ethical nursing practice.

Introduction to Bioethics

The terms **bioethics** and **healthcare ethics** sometimes are used interchangeably. Bioethics, born out of the rapidly expanding technical environment of the 1900s, is a specific domain of ethics focused on moral issues in the field of health care (see **BOX 2-1**). During World War II President Franklin D. Roosevelt assembled a committee to improve medical scientists' coordination in addressing the medical needs of the military (Jonsen, 2000). As often happens with wartime research and advancements, the work aimed at addressing military needs also affected civilian sectors, such as the field of medicine.

Between 1945 and 1965, antibiotic, antihypertensive, antipsychotic, and cancer drugs came into common

BOX 2-1 Early Events in Bioethics

August 19, 1947: The Nuremberg trials of Nazi doctors who conducted heinous medical experiments during World War II began.
April 25, 1953: Watson and Crick published a one-page paper about DNA.
December 23, 1954: The first renal transplant was performed.
March 9, 1960: Chronic hemodialysis was first used.
December 3, 1967: The first heart transplant was done by Dr. Christiaan Barnard.
August 5, 1968: The definition of brain death was developed by an ad hoc committee at Harvard Medical School.
July 26, 1972: Revelations appeared about the unethical Tuskegee syphilis research.
January 22, 1973: The landmark *Roe v. Wade* case was decided.
April 14, 1975: A comatose Karen Ann Quinlan was brought to Newton Memorial Hospital; she became the basis of a landmark legal case about the removal of life support.
July 25, 1978: Baby Louise Brown was born. She was the first test-tube baby.
Spring 1982: Baby Doe became the basis of a landmark case that resulted in legal and ethical directives about the treatment of impaired neonates.
December 1982: The first artificial heart was implanted into the body of Barney Clark, who lived 112 days after the implant.
April 11, 1983: *Newsweek* published a story about a mysterious disease called AIDS that was at epidemic levels.

Data from Jonsen, A. R. (2000). *A short history of medical ethics*. New York, NY: Oxford University Press, pp. 99–114.

> medical use; surgery entered the heart and the brain; organ transplantation was initiated; and life-sustaining mechanical devices, the dialysis machine, the pacemaker, and the ventilator were invented (Jonsen, 2000, p. 99).

However, with these advances also came increased responsibility and distress among healthcare professionals. Patients who would have died in the past began to have a lingering, suffering existence. Healthcare professionals were faced with trying to decide how to allocate newly developed, scarce medical resources. During the 1950s, scientists and medical professionals began meeting to discuss these confusing problems. Eventually healthcare policies and laws were enacted to address questions of who lives, who dies, and who decides. A new field of study was developed called *bioethics*, a term that first appeared in the literature in 1969 (Jonsen, 1998, 2000, 2005).

Ethical Principles

Because shocking information surfaced about serious ethical lapses, such as the heinous World War II Nazi medical experiments in Europe and the unethical Tuskegee research in the United States, societies around the world became particularly conscious of ethical pitfalls in conducting biomedical and behavioral research. In the United States, the National Research Act became law in 1974, and a commission was created to outline principles that must be used during research involving human subjects (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). In 1976, to carry out its charge, the commission held an intensive 4-day meeting at the Belmont Conference Center at the Smithsonian Institute. Thereafter, discussions continued until 1978, when the commission released its report called the *Belmont Report*.

The report outlined three basic principles for all human subjects research: respect for persons, beneficence, and justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The principle of beneficence, as set forth in the *Belmont Report*, is the rule to do good. However, the description

RESEARCH NOTE: TUSKEGEE SYPHILIS STUDY

During the late 1920s in the United States, syphilis rates were extremely high in some areas. The private Rosenwald Foundation teamed with the United States Public Health Service (USPHS) to begin efforts to control the disease using the drug neosalvarsan, an arsenic compound. Macon County, Alabama, particularly the town of Tuskegee, was targeted because of its high rate of syphilis, as identified through a survey. However, the Great Depression derailed the plans, and the private foundation withdrew from the work. The USPHS repeated the Rosenwald survey in Macon County and identified a syphilis rate of 22% among African American men in the county and a 62% rate of congenital syphilis cases. The natural history (progression) of syphilis had not been studied yet in the United States, and the surgeon general suggested that 399 African American men with syphilis in Tuskegee should be observed, rather than treated, and compared with a group of 200 African American men who were uninfected. The men were not told about the details of their disease. They underwent painful, nontherapeutic spinal taps to provide data about the natural history of syphilis and were told these procedures were treatments for "bad blood." The men were given free meals, medical treatment for diseases other than their syphilis, and free burials. Even after penicillin was discovered in the 1940s, the men were not offered treatment. In fact, the USPHS researchers arranged to keep the uninformed study participants out of World War II because the men would be tested for syphilis, treated with penicillin, and lost from the study. The unethical research continued for 40 years, from 1932 to 1972. During the 40 years of research, an astonishing number of articles about the study were published in medical journals, and no attempt was made to hide the surreptitious terms of the research. No one intervened to stop the travesty. Finally, a medical reporter learned of the study, and the ethical issues were exposed.

After reading this chapter and researching more information on the Internet about the Tuskegee research, including the contribution of Nurse Evers, answer the following questions:

1. What were the main social issues with ethical implications involved in this study?
2. Which bioethical principles were violated by the Tuskegee study? Explain.
3. How can various ethical approaches be applied to the Tuskegee study? (Include approaches discussed in an earlier chapter 1.)
4. Discuss the role of Nurse Evers in the Tuskegee research.
5. Which procedures are in place today to prevent this type of unethical research?

of beneficence also included the rule now commonly known as the principle of nonmaleficence, that is, to do no harm. The report contained guidelines regarding how to apply the principles in research through informed consent, the assessment of risks and benefits to research participants, and the selection of research participants.

In 1979, as an outgrowth of the *Belmont Report*, Beauchamp and Childress published the first edition of their book *Principles of Biomedical Ethics*, which featured four bioethical principles: autonomy, nonmaleficence, beneficence, and justice. Currently, the book is in its eighth edition published in 2019, and the principle of autonomy is described as respect for autonomy.

Doing ethics based on the use of principles—that is, ethical **principlism**—does not involve the use of a theory or a formal decision-making model; rather, ethical principles provide guidelines to make justified moral decisions and evaluate the morality of actions. Ideally, when using the approach of principlism, no one principle should automatically be assumed to be superior to the other principles (Beauchamp & Childress, 2019). Each principle is prima facie binding.

Some people have criticized the use of ethical principlism because they believe it is a top-down approach that does not include allowances for the context of individual cases and stories. Critics contend that simply applying principles when making ethical determinations results in a linear way of doing ethics; that is, the fine nuances present in relationship-based situations are not considered adequately. Nevertheless, the approach of ethical principlism using the four principles outlined by Beauchamp and Childress (2019) has become one of the most popular tools used today for analyzing and resolving bioethical problems.

Autonomy

Autonomy is the freedom and ability to act in a self-determined manner. It represents the right of a rational person to express personal decisions independent of outside interference and to have these decisions honored. It can be argued that autonomy occupies a central place in Western healthcare ethics because of the popularity of the Enlightenment-era philosophy of Immanuel Kant. However, it is noteworthy that autonomy is not emphasized in an ethic of care and virtue ethics and these also are popular approaches to ethics today.

The principle of autonomy sometimes is described as respect for autonomy (Beauchamp & Childress, 2019). In the domain of health care, respecting a patient's autonomy includes obtaining informed consent for treatment; facilitating and supporting patients' choices regarding treatment options; allowing patients to refuse treatments; disclosing comprehensive and truthful information, diagnoses, and treatment options to patients so that they can make informed decisions; and maintaining privacy and confidentiality. Respecting autonomy also is important in less obvious situations, such as allowing home care patients to choose a tub bath versus a shower when it is safe to do so and allowing an elderly long-term care resident to choose her favorite foods when they are medically prescribed. In fact, if the elder is competent and has been properly informed about the risks, she has the right to choose to eat foods that are not medically prescribed. Restrictions on an individual's autonomy may occur in cases when a person presents a potential threat for harming others, such as exposing other people to communicable diseases or committing acts of violence; people generally lose the right to exercise autonomy or self-determination in such instances.

FOCUS FOR DEBATE

- Discuss autonomy as it relates to contentious issues among the general public, such as vaccinations and mask-wearing, arising during the Covid-19 pandemic. Defend your views about these issues.

Respecting patients' autonomy is important, but it also is important for nurses to receive respect for their professional autonomy. In considering how the language nurses choose defines the profession's place in health care, Munhall (2012) used the word autonomy (*auto-no-my*) as an example. She reflected on how infants and children first begin to express themselves through nonverbal signs, such as laughing, crying, and pouting, but by the time

FOCUS FOR DEBATE

- During a pandemic, is it ethical for nurses to say "no" to getting themselves vaccinated? Defend your position.
- During a pandemic, is it ethical for nurses to say "no" to wearing a face mask during their work? Outside of their work? Defend your position(s).

children reach the age of 2 years, they usually "have learned to treasure the word *no*" (p. 40). Munhall calls the word *no* "one of the most important words in any language" (p. 40). Being willing and able to reasonably say *no* is part of exercising one's autonomy.

Informed Consent

Informed consent regarding a patient's treatment is a legal and ethical issue of autonomy. At the heart of **informed consent** is respecting a person's autonomy to make personal choices based on the appropriate appraisal of information about the actual or potential circumstances of a situation. Though all conceptions of informed consent must contain the same basic elements, people present the description of these elements differently. Beauchamp and Childress (2019) outlined informed consent according to seven elements (see **BOX 2-2**).

Dempski (2009) presented three basic elements that are necessary for informed consent to occur:

1. Receipt of information: This includes receiving a description of the procedure, information about the risks and benefits of having or not having the treatment, reasonable alternatives to the treatment, probabilities about outcomes, and "the credentials of the person who will perform the treatment" (Dempski, 2009, p. 78). Because it is too demanding to inform a patient of every possible risk or benefit involved with every treatment or procedure, the obligation is to inform the person about the information a reasonable person would want and need to know. Information should be tailored specifically to a person's personal circumstances, including providing information in the person's spoken language.
2. Consent for the treatment must be voluntary: A person should not be under any influence or coerced to provide consent. This means patients should not be asked to sign a consent form when they are under the influence of mind-altering medications, such as narcotics. Depending on the circumstances, such as the riskiness of the procedure, consent may be verbalized, written, or implied by behavior. The more risky the procedure, the more stringent the documentation of the consent should be. Silence does not convey consent when a reasonable person would normally offer another sign of agreement.
3. Persons must be competent: Persons must be able to communicate consent and to understand the information provided to them. If a person's condition warrants transferring decision-making authority to a surrogate, informed consent obligations must be met with the surrogate.

BOX 2-2 Elements of Informed Consent

I. Threshold elements (preconditions)
   1. Competence (ability to understand and decide)
   2. Voluntariness (in deciding)

II. Information elements
   3. Disclosure (of material information)
   4. Recommendation (of a plan)
   5. Understanding (of 3 and 4)

III. Consent elements
   6. Decision (in favor of a plan)
   7. Authorization (of the chosen plan)

Data from Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press, p. 122.

It is neither ethical nor legal for a nurse to be responsible for obtaining informed consent for procedures performed by a physician

(Dempski, 2009). In discussing a lawsuit, nurse and healthcare attorney Carolyn Buppert (2017) reported that some physicians try to delegate informed consent to other healthcare clinicians, such as nurses, nurse practitioners, and physician assistants. In 2017, the Pennsylvania Supreme Court ruled on a lawsuit involving informed consent obtained partially between a patient and a physician assistant and partially between the patient and her physician. The Pennsylvania court upheld a state law that informed consent is a physician's responsibility. Nurses may need to display the virtue of courage if physicians attempt to delegate the total responsibility to them. Though both nurses and physicians in some circumstances may believe nurses are well versed in assuring that the elements of informed consent are met for medical or surgical invasive treatments or procedures performed by a physician, nurses must refrain from accepting this responsibility.

LEGAL PERSPECTIVE

Though they may participate in obtaining a patient's signature, nurses should not obtain informed consent for a provider who will perform a patient's invasive procedure. However, nurses may be legally liable if they know or should have known informed consent was not obtained and they do not appropriately notify providers or supervisors about this deficiency.

On the other hand, it is certainly within a nurse's domain of responsibility to help identify a suitable person to provide informed consent if a patient is not competent; to verify that a patient understands the information communicated by the professional performing the procedure, including helping to secure interpreters or appropriate information for the patient in the patient's spoken language; and to notify appropriate parties if the nurse knows a patient has not given informed consent for a procedure or treatment. In fact, it is ethically incumbent upon nurses to facilitate patients' opportunities to give informed consent. The bottom line is that informed consent is a collaborative process among healthcare professionals and patients.

LEGAL PERSPECTIVE

Assault and battery are two legal terms describing offenses against a person. Both terms are relevant to the ethical requirement of informed consent. **Assault** is the *threat* of harm; for example, someone commits assault if he or she acts or talks in a way that causes another person to feel apprehension about his or her physical safety. **Battery** consists of one person *offensively touching* another person without the person's consent.

Advanced practice nurses are legally and ethically obligated to obtain informed consent before performing risky or invasive treatments or procedures within their scope of practice. In everyday situations, all nurses are required to explain nursing treatments and procedures to patients before performing them. Nursing procedures do not need to meet all the requirements of informed consent if procedures are not risky or invasive (Dempski, 2009). If a patient understands a treatment or procedure and allows the nurse to begin the nursing care, consent has been *implied*. A competent person may convey implied consent when the person participates in or cooperates with an action without explicitly verbalizing consent or formally signing a consent form. Implied consent often is used for low to essentially nonrisky procedures. Healthcare providers need to know when implied consent is acceptable and full informed consent must be obtained. Nurses should keep a heightened awareness to assure that the person is competent to consent to an intervention and does not feel intimidated or coerced into consenting

to a procedure performed by the nurse or any other healthcare worker.

When treatments and procedures that normally require consent need to be performed in an emergency, informed consent should be obtained from the patient if possible. If this is not possible, informed consent should be obtained from the patient's next of kin or surrogate. When reasonable efforts have been made to obtain informed consent, but no one is competent or available to provide the consent or time does not allow for informed consent because of the threat of death and/or disability, it is permissible to proceed with treatments and procedures without informed consent. However, it is important to keep in mind the four main elements that justify a malpractice suit (see **BOX 2-3**) and what a reasonable healthcare professional would do in a situation. The four elements of malpractice are evaluated in all malpractice cases.

BOX 2-3 Four Elements of Malpractice

1. The professional must have a duty to the patient.
2. The professional must have breached that duty.
3. The patient must experience harm or damages.
4. The patient's harm or damages must be directly connected to the professional's negligence. This fourth element involves a situation in which 100% of harm or damages are attributed to the professional's negligent action or maybe only a partial amount is attributed to the action of the professional. For example, the patient also may have contributed to the harm or damages (i.e., contributory negligence).

To decide about malpractice, expert witnesses are used to determine what a similar healthcare professional would do or would have done in a situation like the case at the center of the lawsuit.

Intentional Nondisclosure

In the past, medical and nursing patient care errors were something to be swept under the rug, and care was taken to avoid patient discovery of these errors. However, in the 1990s, when healthcare leaders realized that huge numbers of patients, as many as 98,000 per year, were dying from medical errors, the Institute of Medicine (IOM) began a project to analyze medical errors and try to reduce them. One outcome of the project is the book *To Err Is Human: Building a Safer Health Care System* (IOM, 2000). The IOM project committee determined that to err really is human and good people working within unsafe systems make the most errors.

Based on the IOM's work, it is now expected that errors involving serious, preventable adverse events be reported to patients and through other organizational reporting systems, and possibly external reporting systems, on a mandatory basis (IOM, 2000). This should be easy to understand from an ethics standpoint but reporting *near misses* has been more controversial (Lo, 2009). A near miss is "any event that could have had adverse consequences but did not and was indistinguishable from fully fledged adverse events in all but outcome" (Agency for Healthcare Research and Quality [AHRQ] Patient Safety Network [PSNet], 2019, para. 7). A near miss is like what people commonly think of as a "close call" (para. 7). A patient could have been harmed but was not harmed because of "early detection or sheer luck" (para. 7). An example provided by PSNet is a nurse trying to administer medications to the wrong patient. The patient notices that the medications are not correct for him and harm is avoided. If the patient had been less aware of his correct medications, harm may have occurred.

Some professionals tend to avoid telling patients about near-miss errors because no harm was done to the patient, but ethicists recommend disclosure of these events. Being honest and forthright with patients promotes

trust, and secrecy is unethical (Jonsen et al., 2022). In addition to the direct ethical implications of being honest with patients, much can be learned from investigating the root causes of near-miss errors. Trying to prevent errors is an ethical issue unto itself, which falls under the principle of nonmaleficence (see discussion of this principle later in this chapter).

Intentionally withholding information from a patient or surrogate is legal in emergency situations, as previously discussed, or when patients waive their right to be informed. Respecting a patient's right *not* to be informed is especially important in delivering culturally sensitive care because a person not wanting to know about serious illnesses is sometimes culturally based. Other, more legally and ethically controversial circumstances of intentionally not disclosing relevant information to a patient involve three healthcare circumstances (Beauchamp & Childress, 2019). The first circumstance falls under therapeutic privilege. The second relates to therapeutically using placebos. The third involves withholding information from research subjects to protect the integrity of the research.

By invoking **therapeutic privilege**, physicians were traditionally supported in withholding information from patients if physicians, based on their sound medical judgment, believed "divulging the information would potentially harm a depressed, emotionally drained, or unstable patient" (Beauchamp & Childress, 2019, p. 126). This exception in communication is controversial today. Standards about what constitutes therapeutic privilege have differed among legal jurisdictions with standards ranging from withholding information if a physician believes the information would have *any* negative effect on the patient's health to withholding information only if divulging it is likely to have a *serious* effect. The American Medical Association's (AMA, 2021) current opinion statement, included as part of the AMA's ethics code, indicates that "except in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient's knowledge or consent is ethically unacceptable" (para. 2). The AMA's opinion statement clearly directs physicians to be honest and open with patients about their healthcare status unless a patient has asked not to be informed or the situation is an emergency. A physician does have the leeway in some circumstances, however, to delay telling patients pertinent facts about their condition until the time is deemed safe and appropriate to do so. Disclosure should be delivered in a way that meets the patient's needs and according to an explicit plan to be honest with the patient.

LEGAL PERSPECTIVE

Research the landmark legal case *Canterbury v. Spence* (464 F.2d 772, 782 D.C. Cir. 1972).

- What does it mean to be a *landmark* case?
- What were the bioethical issues involved in the case?
- What was the case outcome?

Placebos, when used therapeutically, are inactive substances given to a patient to induce a positive health outcome through the patient's belief that the inert substance really carries some beneficial power. The patient is unaware that the substance (placebo) is inactive. It is interesting that at least one study has shown placebos can have a positive effect in most patients even when the patients know they are receiving an inert pill (Scuderi, 2011) and this finding is supported by Jonsen and colleagues (2022). Proponents of using placebos say the action is covered under a patient's general consent to treatment, though the consent is not really informed. However, there is a consensus that the therapeutic use of placebos is unethical (Jonsen et al., 2022) because it violates a patient's autonomy and can seriously damage trust between patients and healthcare professionals. The use of placebos is ethical when used properly during experimental research. Participants in a research control group often

are given a placebo so they can be compared to an experimental group receiving the treatment being studied. Research participants are fully informed that they may receive a placebo rather than the actual treatment.

Strict rules apply to research studies requiring that research subjects be protected from manipulation and personal risks. Thus, informed consent in research has stringent requirements. Withholding information from research subjects should never be undertaken lightly. Intentional nondisclosure sometimes is allowed only if the research is relatively risk free to the participants and the nature of the research is behavioral or psychological and disclosure might seriously skew the outcomes of the research.

Patient Self-Determination Act

The Omnibus Reconciliation Act of 1990 (OBRA-90) advance directives provisions are usually referred to as the Patient Self-Determination Act (PSDA). This act passed by the U.S. Congress in 1990 is the first federal statute designed to facilitate a patient's autonomy through the knowledge and use of advance directives. Healthcare providers and organizations must provide written information to adult patients regarding state laws covering the right to make healthcare decisions, refuse or withdraw treatments, and write advance directives (See Appendix C for sample advance directives in Mississippi). One of the underlying aims of the PSDA is to increase meaningful dialogue about patients' rights to make autonomous choices about receiving or not receiving health care.

It is important that dialogue about end-of-life decisions and options is not lost in organizational admission processes and paperwork or in other ways. Nurses provide the vital communication link between the patient's wishes, the paperwork, and the provider. When an appropriate opportunity arises, nurses need to take an active role in increasing their dialogue with patients regarding patients' rights and end-of-life decisions. In addition to responding to the direct questions patients and families ask about advance directives and end-of-life options, nurses would do well to listen to and observe patients' subtle cues that signal their anxiety and uncertainty about end-of-life care. A good example of compassionate care is when nurses actively listen to patients and try to alleviate patients' uncertainty and fears regarding end-of-life decision making.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules

"Within HHS [Health and Human Services], the Office for Civil Rights (OCR) has responsibility for enforcing the [HIPAA] Privacy and Security Rules with voluntary compliance activities and civil money penalties" (U.S. Department of Health and Human Services [HHS], 2013, para. 2). The HIPAA Privacy Rule is a federal regulation designed to protect people from indiscriminate disclosure of their personal health information while supporting dissemination of information needed to achieve high quality health care. It also gives patients the right to review their medical records. The intent of the rule is to ensure privacy while facilitating the flow of information necessary to meet the needs of patients. "The Privacy Rule protects all '*individually identifiable health information*' held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information 'protected health information (PHI)'" (45 C.F.R. § 160.103, as cited in HHS, 2013, para. 14).

The Security Rule of the HIPAA act operationalizes the Privacy Rules. The Security Rule includes standards addressing privacy safeguards for electronic protected health information (HHS, 2020). The rule is designed to "ensure the confidentiality, integrity, and

security of electronic protected health information" (para. 1).

All patient-identifiable protected health information is to be kept private unless it is being used for patient care; a patient agrees to a release; or it is released according to legitimate, limited situations covered by the act. It is incumbent on all healthcare professionals to be familiar with the content of the act. See **BOX 2-4** for healthcare professionals' frequently asked questions about HIPAA. Special topics in information privacy addressed by the Department of HHS (2021) include the following issues, which can be explored via the link provided in this chapter's references:

- HIPAA and Covid-19
- Updated joint guidance on application of HIPAA and FERPA to student health records
- Mental health and substance use disorders
- Research
- Public health
- Emergency situations: Preparedness, planning, and response
- Health information technology
- HIPAA and health apps

BOX 2-4 How Well Do You Know HIPAA?

1. How are covered entities expected to determine what is the minimum necessary information that can be used, disclosed, or requested for a particular purpose?
2. What is the difference between "consent" and "authorization" under the HIPAA Privacy Rule?
3. Can my healthcare provider discuss my health information with an interpreter?
4. Must a healthcare provider or other covered entity obtain permission from a patient prior to notifying public health authorities of the occurrence of a reportable disease?
5. Can the phone number of a patient's room be released as part of the facility directory?
6. What is telehealth?
7. If an individual instructs a covered healthcare provider that he does not want the provider to discuss his medical conditions or treatment with his family members, can the covered entity share such information with family members after the individual has died?
8. Does the HIPAA Privacy Rule permit covered entities to disclose protected health information, without individuals' authorization, to public officials responding to a bioterrorism threat or other public health emergency?
9. May a doctor or hospital disclose protected health information to a person or entity that can assist in notifying a patient's family member of the patient's location and health condition?
10. If I am unconscious or not around, can my healthcare provider still share or discuss my health information with my family, friends, or others involved in my care or payment for my care?
11. Does the HIPAA Privacy Rule permit a doctor to discuss a patient's health status, treatment, or payment arrangements with a person who is not married to the patient or is otherwise not recognized as a relative of the patient under applicable law (e.g., state law)?
12. Does FERPA or HIPAA apply to records on students at health clinics run by postsecondary institutions?
13. May physicians' offices use patient sign-in sheets or call out the names of their patients in their waiting rooms?
14. How do I know if a state law is "more stringent" than the HIPAA Privacy Rule?
15. May a hospital or other covered entity notify a patient's family member or other person that the patient is at their facility?

Find complete answers at *HIPAA FAQ for Professionals*, HHS (2017), https://www.hhs.gov/hipaa/for-professionals/faq/index.html

Nonmaleficence

Nonmaleficence is the principle used to communicate the obligation to do no harm. Emphasizing the importance of this principle is as old as organized medical practice. Healthcare professionals have historically been encouraged to do good (beneficence), but if for some reason they cannot do good, they are required to at least do no harm. Because of the two sides of the same coin connotation between these two principles, some people consider them to be essentially one and the same. However, many ethicists, including Beauchamp and Childress (2019), do make a distinction.

Nonmaleficence is the maxim or norm that "one ought not to inflict evil or harm" (Beauchamp & Childress, 2019, p. 157), whereas beneficence includes the following three norms: "one ought to prevent evil or harm, one ought to remove evil or harm, [and] one ought to do or promote good" (p. 157). As evidenced by these maxims, beneficence involves action to help someone, and nonmaleficence requires "*intentional avoidance* of actions that cause harm" (p. 157). In addition to violating the maxim to not intentionally harm another person, some of the issues and concepts Beauchamp and Childress list as frequently requiring the obligation of nonmaleficence are included in **BOX 2-5**.

LEGAL PERSPECTIVE

Negligence: Failure to render reasonable care, which results in damages or injury.

Malpractice: A negligent act by a professional, usually someone licensed. See the four elements of malpractice in Box 2-3.

Best practice and due care standards are adopted by professional organizations and regulatory agencies to minimize harm to patients. Regulatory agencies develop oversight procedures to ensure that healthcare providers maintain the competence and skills needed to properly care for patients. Nonmaleficence has a wide scope of implications in health care, including the need to avoid negligent care and harm when deciding whether to provide or withhold or withdraw treatment and considerations about rendering extraordinary or heroic treatment.

BOX 2-5 Issues and Concepts Associated with the Principle of Nonmaleficence

- Harm—Something that goes against someone's interests. Note, sometimes harm is justified, for example, a leg amputation due to gangrene.
- Negligence and Due Care—Failure to render reasonable care.
- Nontreatment Decisions—
  - Withholding and withdrawing care
  - Decisions about whether to render medical treatments, including artificial nutrition and hydrations
- The Rule of Double Effect
- Optional Treatments and Obligatory Treatments
- Quality of Life Judgments
- Killing or Letting Die
- Slippery Slope Arguments

Summary from Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). New York, NY: Oxford University Press.

The Case of RaDonda Vaught: First, Do No Harm

The following information about RaDonda Vaught's criminal case has been compiled from multiple Internet sources, including Kelman's (2022, March 27) timeline in the *Tennessean,* a legal discovery document for the *State of Tennessee vs. RaDonda L. Vaught* (2019, March 27), Tennessee Board of Nursing (2019, September 27) documentation, an anonymous complaint (intake number TN00045852) filed with the Department of Health and Human

Services Centers for Medicare and Medicaid Services (DHHS, CMS, 2018, October 13), a statement of deficiencies and plan of correction from Vanderbilt University Medical Center (VUMC) (DHHS, CMS, 2018, November 16), letters sent by the State of Tennessee Department of Health Division of Health Licenses and Regulation Office of Investigations (Welch, 2018, October 23) to Vaught and a Ms. Dubree, a joint *Statement in Response to the Conviction of Nurse RaDonda Vaught* published by the American Nurses Association (ANA) and the Tennessee Nurses Association (TNA) (2022, March 25), copyright free articles published about the case by *Kaiser Health News* (Kelman, 2022, March 22; Kelman, 2022, March 24; Kelman, 2022, March 25; Kelman & Norman, 2022, April 5), and an article published in the *Vanderbilt Hustler* (Oung, 2022, March 31). This case certainly is a landmark case in nursing and health care. An expanded outline of the case is covered here in detail and a related case study is included in Appendix A. The case study provides an opportunity for readers to consider their own interpretation of the case and apply ethical and legal principles. Note, there are some discrepancies in the plethora of information about the case. For example, the medication dispensing machine is called an Acudose in some sources and a Pyxis in other sources. Even the date that Vaught began working at VUMC varies by source.

Date of Incident

The medication error at the heart of this case occurred on **December 26, 2017**.

Relevant Background Information

- RaDonda Vaught, the defendant, was granted a registered nurse (RN) license in the state of Tennessee (TN) on February 13, 2015.
- In November 2015, Vaught began working as a "help all" nurse for the Neuro Intensive Care Unit (NICU), the stepdown, and the sixth floor nursing units at Vanderbilt University Medical Center (VUMC). It seems that her main duties were in the NICU and on the stepdown unit.
- The patient who died as a result of Vaught's error, i.e., the victim, was Charlene Murphey, aged 75, who was admitted to VUMC on December 24, 2017, with a diagnosis of subdural hematoma. The patient was being prepared for hospital discharge when she received the fatal medication administered by Vaught.
- On December 5, 2018, almost one year after her error, Vaught was interviewed by TN Bureau of Investigation (TBI) personnel. Vaught provided the following background information:
  - Vaught said she was comfortable with the "help all" nurse job.
  - She worked December 25 and 26, 2017, on the 7:00 a.m. to 7:00 p.m. shift. The error occurred on December 26, 2017.
  - Vaught denied being overtired on the day of the incident. She also denied that the Neuro Intensive Care Unit (NICU) was understaffed.
  - A new orientee was working with Vaught on the day of the error, but Vaught testified to TBI that she was comfortable having the orientee work with her.

Events on the Day of the Medication Error: December 26, 2017

- Murphey was taken to the radiology department to have a Positron Emission Tomography (PET) scan.
- The patient was alert and oriented when she arrived for the scan. However, she told the radiology tech that she was anxious and claustrophobic.
- The radiology tech conveyed this information to Murphey's primary nurse (not

Vaught) who obtained a verbal order for 1 mg of Versed to be administered intravenously before the scan.

- Murphey's primary nurse asked Vaught (the help all nurse) to administer the Versed.
- The order for Versed was entered into Murphey's medical record on December 26, 2017, at 2:47 p.m. The pharmacy verified the order for Versed at 2:49 p.m. When Vaught went to the Acudose (or Pyxis) system at 2:59 p.m., she did not find the order in the patient's profile. She checked the Medication Administration Record (MAR) in a different computer and saw the order. Since the order was not in the dispensing device's patient profile, Vaught overrode the system and typed in "VE" to search for the Versed. She selected the first medication from the list that began with the letters VE, which was vecuronium bromide. Versed was listed in the dispensing system by its generic name midazolam. Vaught told the TBI interviewers that she could not remember the reason she entered into the dispensing system to account for the override.
- According to Vaught,
  - She looked at the back of the vial but not the front of the vial. Note, the cap of the vecuronium vial includes a warning. See picture.
  - She recognized that the medication needed to be reconstituted.
  - She and her orientee took the medication to the radiology department.
  - She located Murphey and verified Murphey's identity.
  - She reconstituted the vecuronium and administered 1 mg to Murphey.
  - She could not find a computer to scan the medication administration. The medication administration was never scanned.
  - After administering the medication, she left the patient with the radiology technician.
- After the scan (about 20–30 minutes), Murphey was identified as being unconscious. Cardiopulmonary resuscitation (CPR) was initiated, and the patient was placed on a ventilator.
- When the patient arrived back at the NICU, Vaught informed a physician and a nurse practitioner that she had administered vecuronium to Murphey. Vaught told TBI personnel that their response was "I'm so sorry." Note, details were not found that indicated how Vaught knew at this point that she had administered the incorrect medication other than the fact that the patient was unconscious.
- The patient was diagnosed with brain death, was removed from the ventilator, and expired within 12 hours after the vecuronium administration.

Prosecutors filed these side-by-side photos in the case of *RaDonda Vaught* to show warnings that the nurse must have overlooked. *Davidson County Court Records.*

Vaught's Work Repercussions

- Vaught received a termination letter dated January 3, 2018, from VUMC. Termination was based on her failure to "validate the five rights of medication administration." She was not eligible for rehire.
- Thus, Vaught worked at VUMC from November 2015 to January 2018.
- After Vaught was fired by VUMC, she began working as a "throughput coordinator" at TriStar Centennial Medical Center in Nashville. Her position was nonclinical but did require a nursing license.

The Cover-up

- Vaught later told TBI investigators that after the patient returned to the NICU from the PET scan, the unit manager advised Vaught not to scan the medication; the MAR would note it.
- After Murphey's death, two VUMC neurologists report Murphey's death to the Davidson County Medical Examiner without mentioning the medication error, that is, they did not mention that the patient had received vecuronium instead of Versed. The patient's death was deemed to be natural and due to a brain bleed. No investigation was done by the medical examiner since inaccurate information was received.
- VUMC personnel did not report the fatal error to government agencies or the public. It was not reported, as required by law, to either state or federal officials. It also was not reported to the Joint Commission, which accredits VUMC. Death as a result of a medication error is considered to be a sentinel event.
- VUMC negotiated an out-of-court monetary settlement with Murphey's family. The settlement stipulated that the family could not speak publicly about the patient's death or the medication error.
- Someone anonymously reported the medication error and Murphey's death to the DHHS CMS and to the TN Department of Health. The TN Department of Health alerted the TN Bureau of Investigation. The DHHS CMS intake report dated October 3, 2018, is available online.
- The TN Department of Health, which oversees licensing of healthcare professionals, decided not to pursue disciplinary action against Vaught based on the anonymous complaint. Letters dated October 23, 2018, which were sent to Vaught and a Ms. Dubree indicated that Vaught's case had been investigated, but it was determined that the nurse had not violated professional rules and statutes.
- Because of the anonymous complaint, CMS made a surprise visit to VUMC. An investigation regarding the complaint was conducted from October 31, 2018, until November 8, 2018. The facts of the complaint were confirmed by CMS during the investigation. VUMC was threatened with losing Medicare payments, but instead, the hospital was allowed to respond with a plan of correction to satisfy CMS. VUMC would not release the plan of correction to the public, but it was obtained by *The Tennessean* through a public records request.
- The public learned of the incident surrounding Murphey's death in late November 2018.

TN Bureau of Investigation Report

- Vaught was interviewed by two investigators at TBI on December 5, 2018.
- Vaught voluntarily waived her constitutional rights during the interview.
- Vaught provided her recall of what happened surrounding the events of the medication error. She admitted her error.
- Regarding her medication error, Vaught admitted the following:
  - She had administered Versed before, but she had never administered vecuronium bromide.
  - She was distracted by talking to her orientee nurse about the patient's test that was to be done. She admitted that she should have been focused on dispensing and administering the medication.
  - She should not have overridden the medication system, even though it was a common practice at the facility. Vaught admitted that her override was not urgent since the order for Versed was not an emergency.

- She thought it was "a little odd" that she had to reconstitute the medication.
- She did not remember anything on the vecuronium vial to alert her to the fact that the medication was not Versed, though she also said she should have recognized that she was not preparing to administer Versed (see image in page 39).
- Vaught said she should have called the pharmacy to check the order for the Versed.
- She described her thinking: "I probably just killed a patient;" "What did I do to this patient if I didn't kill her?;" "What kind of life changing things did I just put this patient and her family through?;" "It's a horrible situation."
- She used an expletive to describe what she had done.

After Exposure of the Medication Error

- On February 4, 2019, Vaught was arrested based on a criminal indictment and charged with reckless homicide in violation of Tenn. Code Ann. §39-13-25, which is a class D felony. She also was charged with knowing physical abuse or gross neglect of an impaired adult in violation of Tenn. Code Ann. §71-6-119. This is when Vaught was publicly identified for the first time in connection with the incident.
- On February 5, 2019, VUMC officials finally admitted they provided a settlement to Murphey's family, they failed to report the death to state regulators, and their response to the incident was "too limited." VUMC officials met with the TN Board of Licensing Health Care Facilities, but VUMC received no disciplinary action.
- Vaught stated in a GoFundMe post on February 8, 2019, that people believed it is dangerous to indict and incarcerate a nurse for a medical error.
- Vaught entered a plea of not guilty on February 20, 2019, when she first appeared in court for her criminal case. Several dozen nurses who were not from TN showed up to give support to Vaught. Vaught's attorney cast blame on VUMC for the systematic problems with the medication dispensing units.
- The Nashville Medical Examiner changed the cause of Murphey's death to accidental.
- On September 27, 2019, the TN Department of Health and Board of Nursing reversed its decision that Vaught's error did not warrant disciplinary actions. According to Kelman (2022, March 27), the Board gave no reason for the reversal. In addition to noting that Vaught violated the five rights of medication administration, the Tennessee Board of Nursing (2019, September 27) noted in its document, *Notice of Hearing and Charges and Memorandum for Assessment of Civil Penalties,* that Vaught did not stay with the patient after administering the medication, she failed to monitor the patient, and she failed to document administering the vecuronium in the patient's record. The formal alleged violations that constituted grounds for discipline were cited verbatim as:
  - Is guilty of unprofessional conduct,
  - Failure to maintain a record for each patient which accurately reflects the nursing problems and interventions for the patient and/or failure to maintain a record for each patient which accurately reflects the name and title of the nurse providing care, and
  - Abandoning or neglecting a patient requiring nursing care (p. 4).
- A full hearing with the Board of Nursing was set for November 20, 2019. Vaught's penalty was scheduled to be set at that hearing. Vaught was still working at Centennial Medical Center at the time the Board notified her there would be a Board

hearing. She continued to work at her job thereafter.
- A legal fight ensued about whether the Board of Nursing's disciplinary hearing should be held before or after the criminal trial.
- In the spring of 2020, the COVID-19 pandemic caused both the disciplinary and criminal proceedings to be postponed.
- On July 22, 2021, Vaught's Board of Nursing disciplinary hearing began.
- At the hearing, Vaught admitted her error and accepted fault. However, she and her attorney exposed problems in the VUMC healthcare system and accused VUMC of contributing to Vaught's error.
- During the Board of Nursing hearing, the following points were included in Vaught's and her attorney's accusations of VUMC's contribution to the error:
  - At the time of the error, VUMC was having communication problems between electronic health records, medication dispensing units, and the hospital's pharmacy.
  - Medication access was delayed, and hospital personnel were allowed to override safeguards as a short-term workaround.
  - Vaught reported that overriding the medication dispensing system was an everyday practice. Overrides were even needed to obtain intravenous fluids.
- On July 23, 2021, the TN Board of Nursing revoked Vaught's nursing license. Though the Board members seemed sympathetic to Vaught, one member said that "mistakes have consequences."
- Jury selection began on March 21, 2022, for Vaught's criminal trial.
- After about 4 hours of deliberation, the jury delivered the verdict on March 25, 2022, that Vaught was guilty of criminally negligent homicide and abuse of an impaired adult. She was acquitted of reckless homicide. Her charge of negligent homicide is a lesser charge.
- Vaught faced up to 6 years in prison for neglect and up to 2 years in prison for negligent homicide. She was sentenced on May 13, 2022. Though she could have received the harsher sentence, she was granted a judicial diversion. She was given three years probation with the opportunity to have her record expunged at the end of the probation.

Other Information to Consider

- Errors committed by healthcare professionals usually are handled civilly with monetary penalties and through licensing board disciplinary procedures rather than as criminal acts.
- Vaught reported that within 3 days, Murphey's care involved at least 20 overrides of the medication dispensing unit.
- A VUMC pharmacy medication safety officer testified at Vaught's trial that there were technical problems with the medication dispensing units in 2017, but these problems were resolved weeks before Vaught retrieved the incorrect medication.
- Vecuronium is a very dangerous drug to override.
- Vaught's case is "every nurse's nightmare."
- The prosecutor at Vaught's trial compared her to a drunk driver who killed a bystander. He said it was like she was driving with her eyes closed.
- The ANA and TNA contended that the case was a criminalization of honest reporting of an error. Organizational representatives argued that it is unrealistic to believe that mistakes will not happen and that systems will not fail. They proposed that the *Vaught* verdict would further negatively impact the nursing profession that already is strained.
- The *Vaught* case legally could be precedent-setting for healthcare professionals.
- Healthcare professionals have tried to move toward a "just culture," in which medical and nursing errors are properly

analyzed and systems are changed to prevent the same errors in the future. A just culture moves away from personal blame and cover-ups. The *RaDonda Vaught* case could disrupt the cultivation of a just culture.

- The circumstances of the case appear to show that VUMC attempted a cover-up of the incident. Vaught admitted her error.
- The following information was taken from a *Vanderbilt Hustler* article authored by Katherine Oung, the forum's Deputy News Editor (2022, March 31). The *Vanderbilt Hustler* is a news forum for Vanderbilt University and students.
    - Comments from the Davidson County District Attorney: "Multiple health care professionals were on the jury…The jury felt this level of care was so far below the proper standard of a reasonable and prudent nurse that the verdict was justified" (para. 3).
    - A former editor-in-chief of the *American Journal of Nursing*, Maureen Shawn Kennedy, was interviewed for the article. Kennedy called Vaught's error "horrendous," but she stated she did not believe jail time was warranted. She indicated that she believed this trial will be precedent-setting.
    - VUMC personnel would not comment to Oung about Vaught's criminal proceedings.
    - The article notes that the Davidson Count District Attorney's office denies that the verdict is precedent-setting.

Futility

The issues and concepts included in Box 2-5 often are associated with end-of-life care. Violating the principle of nonmaleficence may involve issues of medical futility. Though it sometimes is difficult to accurately predict the outcomes of all interventions, **futile treatments** are treatments a healthcare provider, when using good clinical judgment, does not believe will provide a beneficial outcome for a patient. Consequently, these treatments may instead cause harm to a patient, such as a patient having to endure a slow and painful death that may have otherwise occurred in a quicker and more natural or humane manner. Clinical judgments usually are made in the face of uncertainty (Jonsen et al., 2022), even though medical probabilities often are fairly clear.

Healthcare professionals are not ethically bound to deliver futile treatments. A simplistic example follows: A patient or surrogate cannot legitimately demand that a provider administer an antibiotic to a patient to treat a virus. Antibiotics are not biologically plausible treatments for viruses. Hence, the treatment would be futile, or ineffective. Antibiotic treatment involves risks to patients as well as to the public through the development of drug resistance when antibiotics are used inappropriately. This example is easy to understand, but as the complexity of potentially futile treatments increases, the likelihood of needing to navigate confusing situations with ethical and legal pitfalls also increases. Cases of potential futility that involve differing recommendations between healthcare providers or healthcare providers and/or patients and families should be referred to and discussed by ethics committees. Often, when the potential patient outcomes

LEGAL PERSPECTIVE

- Research laws about healthcare professionals discontinuing ventilator support for a patient in the presence of brain death.
- Discuss ethical issues and outcomes when a family does not voluntarily accept withdrawing ventilation in such cases. Provide specific cases to illustrate your findings.

are obscure, ethics committees err on the side of recommending the treatment desired by the patient and/or family, especially to avoid legal repercussions and maintain the goodwill of the family and the larger community.

Rule of Double Effect

The **rule, or doctrine, of double effect** is mentioned in Box 2-5. This doctrine is attributed to the Medieval saint Thomas Aquinas (1224–1274) from his book *Summa Theologica* (Aquinas, 1947). Aquinas opposed saint Augustine's earlier position that it is unjust for a person to kill another person in self-defense. Details of both arguments can be found in *Summa Theologica*, but Aquinas's basic premise for justifying killing in self-defense is that an act can have two effects—one effect is the intended effect (self-defense) and the other effect is "beside the intention" (killing another person during self-defense actions) (Question 64, Article 7). Aquinas argued that moral acts are judged on what is intended, not what is accidental. He further stipulated that the person acting in self-defense should use force only in proportion to what is needed for one's personal defense and that it should not be done with "private animosity" (Question 64, Article 7).

In health care, performing some actions may have two potential outcomes. One is the intended good outcome, but to achieve the good outcome, a second, less acceptable outcome also might be foreseen to occur. In these situations, one must gauge and balance actions according to their good, intended effects as compared to their possible harmful, adverse effects. For example, although research has shown that giving morphine in regular, increasing increments for pain or respiratory distress at the end of life rarely causes complete cessation of respirations, it is possible for respiratory arrest to occur in this type of situation. It is legal and ethical for healthcare professionals to treat pain and respiratory distress, particularly at the end of life, with increasing increments of morphine even though it is foreseen that cessation of respirations *may* occur. "The nurse should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and may not act with the sole intent to end life" (American Nurses Association [ANA], 2015, p. 3). The terms *killing* and *letting die* raise issues of legality, ethics, homicide, suicide, euthanasia, acts of commission and omission, and active–passive distinctions, which are beyond the scope of this chapter.

ETHICAL REFLECTION

Research examples of using the rule of double effect in health care. Debate the ethics of these examples.

Slippery Slope Arguments

Often, a **slippery slope argument** is a metaphor used as a "beware the Ides of March" warning with no justification or formal, logical evidence to back it up (Ryan, 1998, p. 341). A slippery slope situation is one that may be morally acceptable when the current, primary event is being discussed or practiced but later could hypothetically slip toward a morally unacceptable situation. A slippery slope situation is somewhat like a runaway horse that cannot be stopped after the barn door is left open. People using a slippery slope argument tend to believe the old saying that when people are given an inch, they eventually may take a mile. Because it is argued that harm may be inflicted if the restraints on a particular practice are removed, sometimes, the concept of the slippery slope is considered to fall under the principle of nonmaleficence.

Slippery slope arguments may move toward illogical extremes. Therefore, people who are afraid of a dangerous slide to the bottom of the slope on certain issues need to find evidence justifying their arguments rather than trying to form public opinions and policies

based only on alarmist comparisons. One example of a slippery slope debate occurred with the legalization of physician-assisted suicide (PAS), such as the acts legalized by the Oregon Death with Dignity Act. Proponents of the slippery slope argument say allowing PAS (now also known as physician assisted death or medical aid in dying), which involves a patient's voluntary decision and self-administration of lethal drugs in well-defined circumstances, may or may not in itself be morally wrong. However, slippery slope proponents argue the widespread legalization of PAS may lead to the eventual legalization of nonvoluntary practices of euthanasia. The Oregon Death with Dignity Act was passed in October 1997, and as of 2022, no slide toward the legalization of nonvoluntary euthanasia has occurred in the United States even though other states also have legalized PAS or physician-assisted death (PAD). Opponents of slippery slope arguments believe people proposing these arguments mistrust people's abilities to make definitive distinctions between moral/legal and immoral/illegal issues and exercise appropriate societal controls.

FOCUS FOR DEBATE

Though the procedure currently is illegal in the United States, other countries, such as the United Kingdom and Ukraine, have allowed in vitro fertilization using the DNA from three people to prevent mitochondrial diseases in babies.

1. Search the Internet and check the status of the ethical positions and laws regarding three-parent babies.
2. Is this type of procedure a slippery slope issue? Why or why not?

Beneficence

The principle of beneficence consists of "acts or qualities of mercy, kindness, friendship, generosity, charity and the like" (Beauchamp & Childress, 2019, p. 217). **Beneficence** means people take actions to benefit and promote the welfare of other people. Examples of moral rules and obligations underlying the principle of beneficence are listed in **BOX 2-6**.

BOX 2-6 Rules of Beneficence

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
4. Help persons with disabilities.
5. Rescue persons in danger.

Data from Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). New York, NY: Oxford University Press, p. 219.

Whereas people are obligated to act in a nonmaleficent manner toward all people—that is, not to harm anyone—there are limits to beneficence or the benefits people are expected to bestow on other people. Generally, people act more beneficently toward people whom they personally know or love rather than toward people not personally known to them, though this certainly is not always the case.

Because of professional standards and social contracts, physicians and nurses have a responsibility to be beneficent in their work. Nurses are directed in Provision 2.1 of the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015) to have their patients' interests and well-being as their primary concern. Therefore, though sometimes there are limits to the good nurses can do, nurses have a more stringent obligation to act according to the principle of beneficence than does the general public. Doing good toward and facilitating the well-being of one's patients is an integral part of being a moral nurse.

The Latin term *supererogation* "refers to the act of paying out more than is required or demanded" (Heyd, 1982, p.1). It sometimes is considered in conjunction with saintliness or a person being a hero (Urmson, 1958).

In his 1982 book *Supererogation*, Heyd outlined a theory of supererogation as being separate from other moral theories. He proposed four conditions that define supererogation.

An act is supererogatory if and only if:

1. It is neither obligatory nor forbidden.
2. Its omission is not wrong—and does not deserve sanction or criticism—either formal or informal.
3. It is morally good, both by virtue of its (intended) consequences and by virtue of its intrinsic value (being beyond duty).
4. It is done voluntarily for the sake of someone else's good and is thus meritorious (p. 115).

The bottom line is deciding what the limits of a person's or group's duties are and how beneficent they should be. Nurses need to be aware of particular issues of supererogation. One issue to analyze is current guidance by the ANA at a given point in time. The ANA provides position statements covering issues such as nurses' obligations when they themselves may be at risk of harm from the patient care they provide.

Paternalism

Occasionally, healthcare professionals may experience ethical conflicts when confronted with having to make a choice between respecting a patient's right to self-determination (autonomy) and doing what is good for a patient's well-being (beneficence). Sometimes, healthcare professionals believe they, not their patients, know what is in a patient's best interest. In these situations, healthcare professionals may be tempted to act in ways they believe promote a patient's well-being (beneficence) when the actions actually are a violation of a patient's right to exercise self-determination (autonomy). The deliberate overriding of a patient's opportunity to exercise autonomy because of a perceived obligation of beneficence is called **paternalism**. The word reflects its roots in fatherly or male (paternal) hierarchical relationships, governance, and care. When pondering paternalism, one might think of the title of the 1954 television show *Father Knows Best*.

If a nurse avoids telling a patient that her blood pressure is elevated because the nurse believes this information will upset the patient and consequently further elevate her blood pressure, this is an example of paternalism. A more ethical approach to the patient's care is to unexcitedly give the patient truthful information while helping her remain calm and educating her about successful ways to manage her blood pressure.

Two types of paternalism are listed in **BOX 2-7**. Although paternalism once was a common practice among healthcare professionals, in general, healthcare professionals are discouraged from using it today. Paternalism is still a common practice in certain situations and among people of some cultures who, for example, believe people with authority, such as physicians or male family members, should be allowed to make decisions in the best interests of patients and patients should not be given bad news, such as a terminal diagnosis.

FOCUS FOR DEBATE

Motorcycle helmet laws vary among states from no law to a law based on age or a law for all riders. Should it be legal to mandate that motorcycle riders wear a helmet if they do not want to wear one? Is it ethical? Consider: A person who is not wearing a helmet and is injured on a motorcycle might incur costly health care. Persons incurring such costs may theoretically increase the cost of health care for other people.

Second Victim Phenomenon

A situation when the principle of beneficence is needed, which may not often be recognized

BOX 2-7 Types of Paternalism

- Soft paternalism: The use of paternalism to protect persons from their own nonvoluntary conduct. People justify its acceptance when a person may be unable to make reasonable, autonomous decisions. Examples of when soft paternalism is used include situations involving depression, dementia, substance abuse, and addiction.
- Hard paternalism: "Interventions intended to prevent or mitigate harm to or to benefit a person, even though the person's risky choices and actions are informed, voluntary, and autonomous" (Beauchamp & Childress, 2019, p. 233).

According to Beauchamp and Childress (2013), the following is a summary of justifiable reasons to practice hard paternalism:

1. A patient is at risk of a significant, preventable harm or failure to receive a benefit.
2. The paternalistic action will probably prevent the harm or secure the benefit.
3. The prevention of harm to the patient outweighs risks to the patient of the action taken.
4. There is no morally better alternative.
5. The least autonomy-restrictive alternative that will prevent the harm or secure the benefit is adopted (p. 238).

Data from Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). New York, NY: Oxford University Press.

but should be discussed more often, involves the *second victim phenomenon*. As discussed earlier in this chapter, the IOM began a project in the 1990s to study and reduce the plethora of healthcare errors. Findings from the project revealed that well-intentioned professionals in the midst of flawed processes and communication systems make many preventable errors. Real people are involved in these flawed healthcare systems, and errors committed by these people take a personal toll on them (Scott, 2011).

A physician, Albert Wu (2000), coined the term *second victim* in an editorial in the *British Medical Journal*. He provided an example of a medical resident who made a serious error in interpreting a patient's electrocardiogram, and the resident consequently was labeled as being incompetent. Wu lamented the fact that physicians are the victims of "an expectation of perfection" (p. 726). He proposed that healthcare professionals, including nurses and pharmacists, who make mistakes are the "second victims" along with patients who are the "first and obvious victims of medical mistakes" (p. 726). Though Wu did not directly mention the principle of beneficence (doing good) or the virtue of benevolence (being kind), he did advocate that second victims need help from their colleagues to navigate the "grieving process" that occurs after one makes a serious mistake (p. 727). Two well-publicized cases of the second victim phenomenon center on nurses Julie Thao and Kimberly Hiatt. Mistakes made by these nurses resulted in patient deaths and tragic outcomes for the nurses, especially in the case of Hiatt.

ETHICAL REFLECTION

1. Search the Internet and learn about the cases of nurses Julie Thao and Kimberly Hiatt.
2. List and discuss lessons that you and all healthcare professionals can learn from these two cases.
3. Describe how the principle of beneficence and the virtue of benevolence could be applied to these cases.
4. In addition to benevolence, which other virtues exhibited by their colleagues might have helped Thao and Hiatt?
5. Discuss personal virtues that might be helpful to second victims themselves in navigating the grieving process.

Justice

Justice, as a principle in healthcare ethics, refers to fairness; treating people equally and without prejudice; and the equitable distribution of benefits and burdens, including assuring fairness in biomedical research. Most of the time, difficult healthcare resource allocation decisions are based on attempts to answer questions regarding who has a right to health care, how much health care a person is entitled to, and who will pay for healthcare costs. Remember, however, that justice is one of Plato's cardinal virtues (see an earlier chapter 1). This means that justice is a broad concept in the field of ethics and considered to be both a principle and a virtue.

Social Justice

Distributive justice refers to the fair allocation of resources, whereas **social justice** represents the position that benefits and burdens should be distributed fairly among members of a society or, ideally, that all people in a society should have the same rights, benefits, and opportunities. The mission to define and attain some measure of social justice is an ongoing and difficult activity for the world community. One only needs to think about the obligations of beneficence to identify how these two principles are related. For example, what are the limits of the obligation that people must do good in distributing their assets to help others?

An analysis of social justice mostly has been used to evaluate the powers of competing social systems and the application of regulatory principles on an impartial basis. Theories of social justice differ to some extent, but most of the theories are based on the notion that justice is related to fair treatment and similar cases should be treated in similar ways. People who take a communitarian approach to social justice will seek the common good of the community rather than maximizing individual benefits and freedoms. If people think beyond borders in promoting social justice, they consider how basic health care for all people can be provided and what can be done to prevent social injustice worldwide, such as ways to alleviate poverty, hunger, and abuse.

In his book, *A Theory of Justice*, John Rawls (1971) proposed that fairness and equality be evaluated under a **veil of ignorance**. This concept means that if people had a veil to shield themselves from their own or others' economic, social, and class standing, each person would be likely to make justice-based decisions from a position free of biases. Consequently, each person would view the distribution of resources in impartial ways. Under the veil, people would view social conditions neutrally because they would not know what their own position might be when the veil is lifted. This not knowing, or ignorance, of persons about their own social position means they would be unable to gain any type of advantage for themselves by their choices. Rawls advocated two principles of equality and justice: (1) everyone should be given equal liberty regardless of their adversities and (2) differences among people should be recognized by making sure the least-advantaged people are given opportunities for improvement.

In 1974, Robert Nozick presented the idea of an entitlement system in his book *Anarchy, State, and Utopia*. He proposed that individuals

FOCUS FOR DEBATE

Debate the following issues as they relate to obligations of beneficence. What should be the limits of beneficence in these cases?

- Rescuing a person who is drowning. What if the person is drowning in dangerous rapidly flowing water?
- Alleviating global poverty.
- Working as a nurse during a highly lethal pandemic when a vaccination is unavailable and protective equipment is limited.
- Defending the rights of immigrants.

should be entitled to health care and the benefits of insurance only if they are able to pay for these benefits. Nozick emphasized a system of **libertarianism**, meaning justice and fairness are based on rewarding only those people who contribute to the system in proportion to their contributions. People who cannot afford health insurance are disadvantaged if Nozick's entitlement theory is used as a philosophy of social justice.

FOCUS FOR DEBATE

Is it ethical to ration health care to stretch healthcare dollars? Consider the different ways rationing criteria could be established; examples include age, income, social status, and diagnosis and treatment.

In his book, *Just Health Care*, Norman Daniels (1985) used the basis of Rawls's concept of justice and suggested a liberty principle. Daniels advocated national healthcare reform and proposed that every person should have equal access to health care and reasonable access to healthcare services. Daniels suggested there should be critical standards for a fair and equitable healthcare system, and he provided points of reference, or benchmarks, for this application of fairness in the implementation and development of national healthcare reform.

The Patient Protection and Affordable Care Act

Signed into law by President Obama on March 23, 2010, the Affordable Care Act (ACA) was intended to enact comprehensive healthcare reform in the United States, including improving quality and lowering healthcare costs and providing greater access to health care and new consumer protections. The ACA is intended to put members of the American public in charge of their own health care. For a good overview of information about the law, the insurance marketplace created by the law, prevention and wellness benefits, and facts and features of the law, visit the HHS.gov website: About the Affordable Care Act.

Before the enactment of the ACA, the long-standing U.S. healthcare system was based on a philosophy of market justice, that is, distributing health care as an economic good rather than a social good. The changing U.S. philosophy related to the distribution of health care has prompted a battle between people who tend to be libertarians (concerned about individual freedoms) and people who tend to be communitarians (concerned about the common good). Pence (2015) outlined some of the main issues, questions, and positions regarding the ACA:

- Does the ACA provide better efficiency in providing health care, or will the system be bogged down in federal bureaucracy? Medicare, Medicaid, and the Veterans Administration system are cited as success stories, even though each agency has generated both quality and economic concerns. Overall, these federal programs have provided fairly comprehensive health care for large numbers of people and have yet to go broke, as people have feared. On the negative side, historically the federal government is not known for being efficient. The Internet provides a plethora of information about wasteful federal expenditures.
- Does the ACA make medicine rational? On the positive side, the ACA is an effort to control costs, equalize coverage, and make health care a moral endeavor. People against the act say, "the more we move to perfect equality, the more individual liberty vanishes" (Pence, 2015, p. 347). Another point of contention is whether the better availability of health care prompts more people to use resources indiscriminately rather than rationally. This concern

is founded somewhat on a slippery slope argument. This position should rely on research data.

- Is health care a right or a privilege? Many people in the United States consider Medicare coverage to be a right. It is interesting that some of these same people are against a move toward universal coverage under the ACA. Rawls (1971) contended that justice is consistent with fairness within social structures. Health care falls within the American social structure; thus, on the surface of things, it is a right for all citizens. Recall from earlier in this chapter that Rawls's veil of ignorance is a test of how to determine what is just and unjust in an unbiased way. One can ponder, under the veil, how many people would choose to be without basic healthcare coverage when the veil is lifted. Libertarians who are against the ACA contend that:

> America was founded on *negative rights of noninterference*: rights to be left alone, to pursue happiness, and to think, speak, assemble, and worship without interference from government. Such "freedom from" differs dramatically from "freedom to." The latter is a *positive right to some service* from others, that is, an entitlement. (Pence, 2015, p. 347)

One of the conundrums underlying this point of debate is whether minimum or basic health care can be defined at all to determine how far one's rights should be extended. Does the ACA generate a situation of intergenerational injustice? People who oppose the ACA say young generations will be enslaved by taxes to pay for health care for older Americans. People in favor of the ACA say many young people are "free riders" (Pence, 2015, p. 354) of the system and some type of means testing process can be used for more financially secure seniors to pay more for coverage.

FOCUS FOR DEBATE

Take the points of debate offered by Pence and investigate the issues further. Organize and engage in evidence-based debates around these issues and other ACA issues in the literature and on the Internet. Examples for debate include the following questions, but there are other issues that can be debated:

- Is supporting versus not supporting the ACA a matter of ethics?
- Is the social structure of America based on negative or positive rights? Which type of rights supports a more ethical social structure?
- Is health care a right or a privilege?
- Can minimum or basic health care be defined?
- Does the ACA provide a more efficient system of health care?
- Does the ACA set up a situation of intergenerational injustice?
- Does Rawls's veil of ignorance provide a good rationale for why people should support the ACA?
- Does the widespread availability of health care lead to a waste of scarce resources (i.e., can Americans be trusted to use good judgment in how resources are used)?

LEGAL PERSPECTIVE

After passage of the ACA, some politicians engaged in a prolonged attempt to repeal the act or delay implementation based on the premise that the law is unconstitutional; that is, the federal government cannot mandate individuals to purchase health insurance. After the election of President Trump, in December 2017, the individual mandate for insurance was repealed beginning in 2019 by the Tax Cuts and Jobs Act of 2017. Senator Orrin Hatch indicated this repeal started the end of the ObamaCare (i.e., the ACA) era. However, the constitutionality of the ACA was upheld by the U.S. Supreme Court in 2021.

Professional–Patient Relationships

The quality of patient care rendered by healthcare professionals and patients' satisfaction with health care often depend on harmonious relationships between professionals and patients and among the members of professions themselves. If healthcare professionals view life as a web of interrelationships, all their relationships potentially can affect the well-being of patients.

Unavoidable Trust

When patients enter the healthcare system, they usually are entering a foreign and frightening environment (Chambliss, 1996; Zaner, 1991). Intimate conversations and activities, such as being touched and probed, that normally do not occur between strangers are commonplace between healthcare professionals and patients. Patients frequently are stripped of their clothes, subjected to sitting alone in cold and barren rooms, and made to wait anxiously for frightening news regarding the continuation of their very being. When patients need help from healthcare professionals, they frequently feel a sense of vulnerability and uncertainty. The tension patients feel when accessing health care is heightened by the need for what Zaner called **unavoidable trust**. In most cases, when they need care, patients have no option but to trust nurses and other healthcare professionals.

ETHICAL REFLECTION

Suggest nursing actions to decrease patients' uncomfortable feelings when they are experiencing unavoidable trust.

This unavoidable trust creates an asymmetrical, or uneven, power structure in relationships between professionals and patients and the patients' families (Zaner, 1991). Nurses' responsiveness to this trust needs to include the promise to be the most excellent nurses they can be. According to Zaner, healthcare professionals must promise "not only to take care of, but to care for the patient and family—to be candid, sensitive, attentive, and never to abandon them" (p. 54). It is paradoxical that trust is necessary *before* health care is rendered, but it can be evaluated in terms of whether the trust was warranted only *after* care is rendered. To practice ethically, nurses must never take for granted the fragility of patients' trust.

ETHICAL REFLECTION

On the Internet, find the poem "The Operation" by Anne Sexton. Read the poem reflectively, and do the following:

1. Analyze the story, symbolism, and feelings conveyed by Sexton in the poem; discuss and provide specific examples.
2. Discuss your perception of the quality of healthcare provider–patient relationships reflected in the poem; provide specific examples.

Human Dignity

In the first provision of the *Code of Ethics for Nurses with Interpretive Statements*, the ANA (2015) included the standard that a nurse must have "respect for human dignity" (p. 1). Typically, people refer to maintaining dignity regarding the circumstances of how people look, behave, and express themselves when they are being watched by others or are ill, aging, or dying; in circumstances of how people respect themselves and are respected by others; and in the honor accorded to the privacy of one's body, emotions, and personhood. Nurses are charged with protecting a person's dignity during all nursing care, and often a patient's nurse is the primary person who guards a patient's dignity during medical procedures.

Healthcare settings can be scenes of professionals rushing through treatments so they can efficiently move on to the next patient and job to be done. Nurses have many opportunities to be mindful of the person who is the patient: a person who wants to be respected.

Shotton and Seedhouse (1998) said the term *dignity* has been used in vague ways. They characterized dignity as persons being in a position to use their capabilities and proposed that a person has dignity "if he or she is in a situation where his or her capabilities can be effectively applied" (p. 249). For example, a nurse can enhance dignity when caring for an elderly person by assessing the elder's priorities and determining what the elder has been capable of doing in the past and is capable of doing and wants to do in the present.

A lack or loss of capability is frequently an issue for consideration when caring for patients such as children, elders, and persons who are physically and mentally disabled. Having absent or diminished capabilities is consistent with what MacIntyre (1999) referred to in his discussion of human vulnerability. According to MacIntyre, people generally progress from a point of vulnerability in infancy to achieving varying levels of independent, practical reasoning as they mature. However, all people, including nurses, would do well to realize that all persons have been or will be vulnerable at some point in their lives. Taking a "there but for the grace of God go I" stance may prompt nurses to develop what MacIntyre called the virtues of acknowledged dependence. These virtues include *just generosity*, *misericordia*, and *truthfulness* and are exercised in communities of giving and receiving. Just generosity is a form of giving generously without keeping score of who gives or receives the most, *misericordia* is a Latin word that signifies giving without prejudice based on urgent need, and truthfulness involves not being deceptive. Nurses who cultivate these three virtues, or excellences of character, can move toward preserving patients' dignity and working for the common good of a community.

Patient Advocacy

Nurses acting from a point of patient advocacy try to identify unmet patient needs and then follow up to address the needs appropriately (Jameton, 1984). Advocacy, as opposed to advice, involves the nurse moving from the patient to the healthcare system rather than moving from the nurse values to the patient. The concept of advocacy has been a part of the ethics codes of the International Council of Nurses (ICN) and the ANA since the 1970s (Winslow, 1988). In the *Code of Ethics for Nurses with Interpretive Statements*, the ANA (2015) continues to support patient advocacy by elaborating on the "primacy of the patient's interest" (p. 5) and requiring nurses to work collaboratively with others to attain the goal of addressing the healthcare needs of patients and the public. Nurses are called upon to ensure that all appropriate parties are involved in patient care decisions, patients are provided with the information needed to make informed decisions, and collaboration is used to increase the accessibility and availability of health care to all patients who need it. The ICN (2021), in its *Code of Ethics for Nurses*, affirms that "nurses are patient advocates and they maintain a practice culture that promotes ethical behavior and open dialogue" (p. 12).

Moral Suffering

Many times, healthcare professionals experience a disquieting feeling of anguish, uneasiness, or angst that can be called **moral suffering**. Suffering in a moral sense has similarities to the Buddhist concept of *dukkha*, a Sanskrit word translated as suffering. *Dukkha* "includes the idea that life is impermanent and is experienced as unsatisfactory and imperfect" (Sheng-yen, 1999, p. 37). The concept of *dukkha* evolved from the historical Buddha's belief that the human conditions of birth, sickness, old age, and death involve suffering and *are* suffering. Nurses confront these human

conditions every day. Not recognizing, and in turn struggling against, the reality that impermanence, or the changing and passing away of all things, is inherent to human life, the world, and all objects is a cause of suffering.

Moral suffering can be experienced when nurses attempt to sort out their emotions when they find themselves in imperfect situations that are morally unsatisfactory or forces beyond their control prevent them from positively influencing or changing unsatisfactory moral situations. Suffering occurs because nurses believe situations must be changed or fixed to bring well-being to themselves and others or to alleviate the suffering of themselves and others.

Moral suffering may arise, for example, from disagreements with imperfect institutional policies, such as an on-call policy or work schedule the nurse believes does not allow relaxation time for the nurse's psychological well-being. Nurses also may disagree with physicians' orders that the nurses believe are not in patients' best interests, or they may disagree with the way a family treats a patient or makes patient care decisions. Moral suffering can result when a nurse is with a patient when the patient receives a terminal diagnosis or when a nurse's compassion is aroused when caring for a severely impaired neonate or an elder who is suffering, and life-sustaining care is either prolonged or withdrawn. These are but a few examples of the many types of encounters nurses may have with moral suffering.

Another important, but often unacknowledged, source of moral suffering may occur when nurses freely choose to act in ways they, themselves, would not defend as being morally commendable if the actions were honestly analyzed. For example, a difficult situation that may cause moral suffering for a nurse would be covering up a patient care error made by herself or himself or a valued nurse friend. On the other hand, nurses may experience moral suffering when they act virtuously and courageously by doing what they believe is morally right despite anticipated disturbing consequences. Sometimes, doing the right thing or acting as a virtuous person would act is hard, but it is incumbent upon nurses to habitually act in virtuous ways, that is, to exhibit habits of excellent character.

The Dalai Lama (1999) proposed that how people are affected by suffering is often a matter of choice or personal perspective. Some people view suffering as something to accept and transform if possible. Causes may lead toward certain effects, and nurses are often able to change the circumstances or conditions of events so positive effects occur. Nurses can choose and cultivate their perspectives, attitudes, and emotions in ways that lead toward happiness and well-being even in the face of suffering.

ETHICAL REFLECTION

- Have you experienced moral suffering during your work as a nurse or student nurse? Describe it.
- How can this experience help you grow as a kind person and nurse?

The Buddha was reported to have said, "Because the world is sick, I am sick. Because people suffer, I have to suffer" (Hanh, 1998, p. 3). However, in the Four Noble Truths, the Buddha postulated that the cessation of suffering can be a reality through the Eightfold Path of eight right ways of thinking, acting, and being, sometimes grouped under the three general categories of wisdom, morality, and meditation. In other words, suffering can be transformed. When nurses or other healthcare professionals react to situations with fear, bitterness, and anxiety, it is important to remember that wisdom and inner strength are often increased most during times of the greatest difficulty. Thich Nhat Hanh (1998) wisely stated, "without suffering, you cannot grow" (p. 5). Therefore, nurses can learn to take their disquieting experiences of moral anguish and

uneasiness—that is, moral suffering—and transform them into experiences that lead to well-being.

Ethical Dilemmas

An **ethical dilemma** is a situation in which an individual is compelled to choose between two actions that will affect the welfare of a sentient being and both actions are reasonably justified as being good, neither action is readily justified as being good, or the goodness of the actions is uncertain. One action must be chosen, thereby generating a quandary for the person or group who is burdened with the choice.

Kidder (1995) focused on one characteristic of an ethical dilemma when he described the heart of an ethical dilemma as "the ethics of right versus right" (p. 13). Though the best choice about two right actions is not always self-evident, according to Kidder, right versus right choices clearly can be distinguished from right versus wrong choices. Right versus right choices are nearer to common societal and personal values, whereas the closer one analyzes right versus wrong choices, "the more they begin to smell" (p. 17). He proposed that people generally can judge wrong choices according to three criteria: violation of the law, departure from the truth, and deviation from moral rectitude. Of course, the selection and meaning of these three criteria can be a matter of debate.

When a person is facing a real ethical dilemma, often, none of the available options feel right. Both choices may feel wrong. For a daughter trying to decide whether to withdraw life support from her 88-year-old mother, it may feel wrong not to try to save her mother's life but allowing her mother to suffer in a futile medical condition probably will also feel wrong. On the other hand, for a healthcare professional considering this same case, there may be no real dilemma involved—the healthcare professional may see clearly that the right choice is to withhold or withdraw life support.

FOCUS FOR DEBATE

As this book edition goes to press in 2022, the legality of abortion is evolving. Assuming that abortion is legal, many people believe it is not ethical. Does the legality of abortion affect whether it can be called an ethical dilemma for some people?

Considering the preceding explanations, it is important to note that the words *ethical dilemma* often are used loosely and inappropriately. Weston (2011) stated, "today you can hardly even mention the word 'moral' without 'dilemma' coming up in the next sentence, if it waits that long" (p. 99). He called an ethical dilemma "a very special thing" (p. 99), contending that often, when people believe they face a dilemma, they are facing a "false dilemma"; the person needs only to work on identifying "new possibilities or reframing the problem itself" (p. 99) to solve the problem. As an example, he presented the classic case of the Heinz dilemma used by Lawrence Kohlberg in his research. The story is about Heinz, whose wife is dying of cancer. She needs a particular drug to save her life. The pharmacist who makes the drug charges much more than it costs him to make it. The cost is way beyond what Heinz can afford to pay. Heinz tries to borrow the money needed but is not successful. He asks the pharmacist to sell him the drug at a lower cost, but the pharmacist refuses his request. Finally, Heinz robs the pharmacy to obtain the drug. The question is whether Heinz should have committed the robbery. Did Heinz face a dilemma? Weston discussed the Heinz

ETHICAL REFLECTION

- Explain your analysis of the Heinz dilemma.

dilemma with his students, and they generated some very creative ways of approaching the problem that did not involve robbing the pharmacy.

Introduction to Critical Thinking and Ethical Decision Making

In healthcare and nursing practice, moral matters are so prevalent that nurses often do not even realize they are faced with minute-to-minute opportunities to make ethical decisions (Chambliss, 1996; Kelly, 2000). It is vitally important that nurses have the analytical thinking ability and skills to respond to many of the everyday decisions that must be made. Listening attentively to other people, including patients, and not developing hasty conclusions are essential skills for nurses to conduct reasoned, ethical analyses. Personal values, professional values and competencies, ethical principles, and ethical theories and approaches are variables to consider when a moral decision is made. Pondering the questions "What is the right thing to do?" and "What ought I do in this circumstance?" is an ever-present normative consideration in nursing.

Critical Thinking

The concept of critical thinking is used quite liberally today in nursing. Many nurses probably have a general idea about the meaning of the concept, but they may not be able to clearly articulate answers to questions about its meaning. Examples of such questions include the following: Specifically, what is critical thinking? Are critical thinking and problem-solving interchangeable concepts? If not, what distinguishes them? Can critical thinking skills be learned, or does critical thinking occur naturally? If the skill can be learned, how does one become a critical thinker? Is there a difference between doing critical thinking and reasoning?

Socrates's method of teaching and questioning, covered in an earlier chapter 1, is one of the oldest systems of critical thinking. In modern times, the American philosopher John Dewey (1859–1952) is considered one of the early proponents of critical thinking. In his book *How We Think*, Dewey (1910/1997) summarized reflective thought as:

> active, persistent, and careful consideration of any belief or supposed form of knowledge in light of the grounds that support it, and the further conclusions to which it tends. . . . Once begun it is a conscious and voluntary effort to establish belief upon a firm basis of reasons. (p. 6)

Paul and Elder (2006), directors of the Foundation for Critical Thinking, defined critical thinking as "the art of analyzing and evaluating thinking with a view to improving it" (p. 4). They proposed that critical thinkers have certain characteristics:

- They ask clear, pertinent questions and identify key problems.
- They analyze and interpret relevant information by using abstract thinking.
- They can generate reasonable conclusions and solutions that are tested according to sensible criteria and standards.
- They remain open minded and consider alternative thought systems.
- They solve complex problems by effectively communicating with other people.

The process of **critical thinking** is summarized by Paul and Elder (2006) as "self-directed, self-disciplined, self-monitored, and self-corrective thinking [that] requires rigorous standards of excellence and mindful command of their use" (p. 4). Fisher (2001) described the basic way to develop critical thinking skills as simply "thinking about one's thinking" (p. 5).

Moral Imagination

[Persons], to be greatly good, must imagine intensely and comprehensively; [they] must put [themselves] in the place of another and of many others. . . . The great instrument of moral good is the imagination.

—Percy Bysshe Shelley, *Defense of Poetry*

The foundation underlying the concept of moral imagination, an artistic or aesthetic approach to ethics, is based on the philosophy of John Dewey. Imagination, as Dewey proposed it, is "the capacity to concretely perceive what is before us in light of what could be" (as cited in Fesmire, 2003, p. 65). Dewey (1934) stated imagination "is a way of seeing and feeling things as they compose an integral whole" (p. 267). **Moral imagination** is moral decision making through reflection involving "empathetic projection" and "creatively tapping a situation's possibilities" (Fesmire, 2003, p. 65). It involves moral awareness and decision making that goes beyond the mere application of standardized ethical meanings, decision-making models, and bioethical principles to real-life situations.

ETHICAL REFLECTION

Perform a written self-analysis of your critical thinking skills. What are your strengths? In what ways do you need to improve? Be specific with your analysis.

The use of empathetic projection helps nurses be responsive to patients' feelings, attitudes, and values. To creatively reflect on a situation's possibilities helps prevent nurses from becoming stuck in their daily routines and instead encourages them to look for new and different possibilities in problem solving and decision making that go beyond mere habitual behaviors. Although Aristotle taught that habit is the way people cultivate moral virtues, Dewey (1922/1988) cautioned that mindless habits can be "blinders that confine the eyes of mind to the road ahead" (p. 121). Dewey proposed that habit should be combined with intellectual impulse:

> Habits by themselves are too organized, too insistent and determinate to need to indulge in inquiry or imagination. And impulses are too chaotic, tumultuous and confused to be able to know even if they wanted to. . . . A certain delicate combination of habit and impulse is requisite for observation, memory and judgment. (p. 124)

Dewey (1910/1997) provided an example of a physician trying to identify a patient's diagnosis without proper reflection:

> Imagine a doctor being called in to prescribe for a patient. The patient tells him some things that are wrong; his experienced eye, at a glance, takes in other signs of a certain disease. But if he permits the suggestion of this special disease to take possession prematurely of his mind, to become an accepted conclusion, his scientific thinking is by that much cut short. A large part of his technique, as a skilled practitioner, is to prevent the acceptance of the first suggestions that arise; even, indeed, to postpone the occurrence of any very definite suggestions till the trouble—the nature of the problem—has been thoroughly explored. In the case of a physician this proceeding is known as a diagnosis, but a similar inspection is required in every novel and complicated situation to prevent rushing to a conclusion. (p. 74)

Although Dewey's example is about an individual physician–patient clinical encounter, the example also is applicable for illustrating

the dangers of rushing to conclusions in the moral practice of the art and science of nursing with individuals, families, communities, and populations. The following story provides an example of a nurse not using moral imagination. A young public health nurse moves from a large city to a rural town and begins working as the occupational health nurse at a local factory. The nurse notices that many workers at the factory have developed lung cancer. He immediately assumes the workers have been exposed to some type of environmental pollution at the factory and the factory owners are morally irresponsible people. The nurse discusses his assessment with his immediate supervisor and an official at the district health department. Upon further assessment, the nurse finds data showing the factory's environmental pollution is unusually low. However, the nurse does learn that radon levels are particularly high in homes in the area and a large percentage of the factory workers smoke cigarettes. The nurse plans interventions to increase home radon testing and reduce smoking among employees.

In the following example, a home health nurse uses moral imagination. The nurse visits Mrs. Smith, a homebound patient diagnosed with congestive heart failure. The patient tells the nurse she has difficulty affording her medications and she does not buy the low-sodium foods the nurse recommends because the fresh foods are too expensive. However, the patient's television set broke, and she bought a new, moderately priced television she is usually watching when the nurse visits. The home health aide who visits the patient tells the nurse, "No wonder Mrs. Smith can't afford her medications—she spent her money on a television." Rather than judging the patient, the nurse uses her moral imagination to try to empathetically envision what it must be like to be Mrs. Smith—homebound, consistently short of breath, and usually alone. The nurse decides Mrs. Smith's television may have been money well spent in terms of the patient's quality of life. With Mrs. Smith's physician and social worker, the nurse explores ways to help the patient obtain her medications. The nurse also works patiently with Mrs. Smith to try to develop a healthy meal plan that is affordable for her. Finally, the nurse engages in a constructive, nonthreatening discussion with the home health aide about why negative judgments and conclusions should be carefully considered. She is a mentor to the aide and teaches her about moral imagination.

Dewey (1910/1997) seemed to be trying to make the point that critical thinking and moral imagination require suspended judgment until problems and situations are fully explored and reflected upon. Moral imagination includes engaging in frequent considerations of "what if?" regarding day-to-day life events and novel situations. In a public interview on July 22, 2004, immediately after the U.S. Congress released the *9/11 Commission Report*, former New Jersey governor and 9/11 Commission chairman Thomas Kean made a statement regarding the findings about the probable causes of the failure to prevent the terrorist attacks on September 11, 2001. The commission concluded, above all, that there was a "failure of imagination" (Mondics, 2004, p. A4).

An important role for nurses is to provide leadership and help create healthy communities through individual-, family-, and population-based assessments and program planning, implementation, and evaluation. When assuming this key leadership role, nurses continually make choices and decisions that may affect the well-being of both individuals and populations.

FOCUS FOR DEBATE

- Do members of the nursing profession have an imbalanced focus on the caring nature of nursing, thus minimizing a focus on nurses' scientific knowledge and thereby hurting nursing's public image?
- Do you believe public impressions of the profession have changed in the last decade? Support your answer.

Opinions should not be formed hastily, nor should actions be taken without nurses cultivating and using their moral imaginations.

The High, Hard Ground and the Swampy, Low Ground

It is generally agreed that nursing is based on the dual elements of art and science. Schön (1987) postulated that professional decision points sometimes arise when there is tension between how to attend to knowledge based on technical, scientific foundations and indeterminate issues that lie beyond scientific laws. Schön (1987) described this tension as follows:

> In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solutions. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern. The practitioner must choose. (p. 3)

Gordon and Nelson (2006) argued that nursing has suffered by not emphasizing the profession's scientific basis and the specialized skills required for nursing practice. These authors proposed the professional advancement of nursing has been hurt by nurses and others (including general members of society) focusing too much on the virtues of nurses and the caring nature of the profession, essentially the art of nursing:

> Although much has changed for professional women in the twentieth century, nurses continue to rely on religious, moral, and sentimental symbols and rhetoric—images of hearts, angels, touching hands, and appeals based on diffuse references to closeness, intimacy, and making a difference. . . . When repeated in recruitment brochures and campaigns, appeals to virtue are unlikely to help people understand what nurses really do and how much knowledge and skill they need to do it. (pp. 26–27)

Reflective Practice

Schön (1987) distinguished reflection-*on*-action from reflection-*in*-action. Reflection-on-action involves looking back on one's actions, whereas reflection-in-action involves stopping to think about what one is choosing and doing before and during one's actions. In considering the value of reflection-in-action, Schön (1987) stated, "in an action present—a period of time, variable with the context, during which we can still make a difference to the situation at hand—our thinking serves to reshape what we are doing while we are doing it" (p. 26). Mindful reflection while we are still able to make choices about our behaviors is preferable to looking backward. However, as the saying goes, hindsight is 20/20, so there is certainly learning that can occur from hindsight.

Because ethics is an active process of doing, reflection in any form is crucial to the practice of ethics. Making justified ethical decisions requires healthcare professionals to know themselves and their motives, ask good questions, challenge the status quo, and be continual learners (see **BOX 2-8**). There is no one model of reflection and decision making that can provide healthcare professionals with an algorithm for ethical practice. However, there are models professionals can use to improve their skills of reflection and decision making during their practice. The Five Rs Approach, discussed here, is one such model.

ETHICAL REFLECTION

Use the Gibbs' Cycle (**FIGURE 2-1**), and reflect on a challenging, personal, ethical situation that occurred during your nursing practice or personal life.

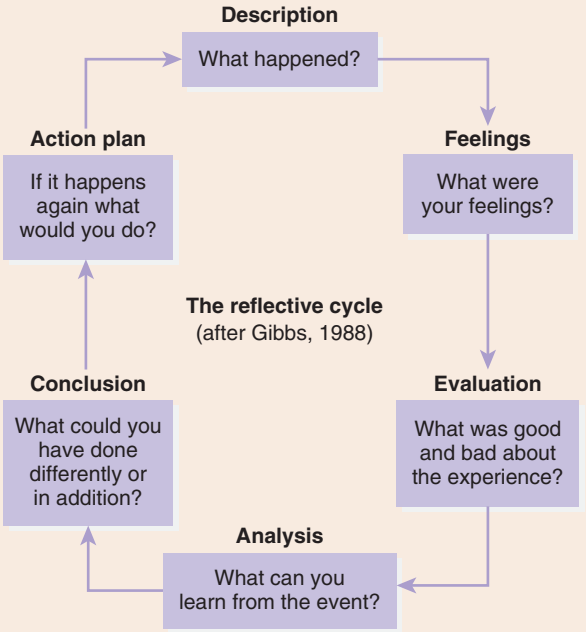

FIGURE 2-1 Gibbs' Reflective Cycle.

Courtesy of Graham Gibbs. (1988). *Learning by doing: A guide to teaching and learning methods*. Oxford, UK: Oxford Polytechnic.

BOX 2-8 The Five Rs Approach to Ethical Nursing Practice

1. **Read** and learn about ethical philosophies, approaches, and the ANA's *Code of Ethics for Nurses*. Insight and practical wisdom are best developed through effort and concentration.
2. **Reflect** mindfully on one's egocentric attachments—values, intentions, motivations, and attitudes. Members of moral communities are socially engaged and focus on the common good. This includes having good insight regarding life events, cultivating and using practical wisdom, and being generous and socially just.
3. **Recognize** ethical bifurcation (decision) points, whether they are obvious or obscure. Because of indifference or avoidance, nurses may miss both small and substantial opportunities to help alleviate human suffering in its different forms.
4. **Resolve** to develop and practice intellectual and moral virtues. Knowing ethical codes, rules, duties, and principles means little without being combined with a nurse's good character.

(continues)

BOX 2-8 The Five Rs Approach to Ethical Nursing Practice *(continued)*

5. **Respond** to persons and situations deliberately and habitually with intellectual and moral virtues. Nurses have a choice about their character development and actions.

Intellectual virtues	Moral virtues
Insight	Compassion
Practical wisdom	Loving-kindness
	Equanimity
	Sympathetic joy

Insight: Awareness and knowledge about universal truths that affect the moral nature of nurses' day-to-day life and work
Practical wisdom: Deliberating about and choosing the right things to do and ways to be that lead to good ends
Compassion: The desire to separate other beings from suffering
Loving-kindness: The desire to bring happiness and well-being to oneself and other beings
Equanimity: An evenness and calmness in one's way of being; balance
Sympathetic joy: Rejoicing in other people's happiness

Considerations for Practice

- Trying to apply generic algorithms or principles when navigating substantial ethical situations does not adequately allow for variations in life narratives and contexts.
- Living according to a philosophy of ethics must be a way of being for nurses before they encounter critical ethical bifurcation points.

The Four Topics Approach to Ethical Decision Making

Jonsen and colleagues' (2022) Four Topics Method for ethical analysis is a practical approach for nurses and other healthcare professionals. The nurse or team begins with relevant facts about a particular case and moves toward a resolution through a structured analysis. In healthcare settings, ethics committees often resolve ethical problems and answer ethical questions by using a case-based, or bottom-up, inductive, casuistry approach. The Four Topics Method, sometimes called the Four Box Approach (**TABLE 2-1**) is found in the book *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (Jonsen et al., 2022).

This case-based approach allows healthcare professionals to construct the facts of a case in a structured format that facilitates critical thinking about ethical problems. Cases are analyzed according to four topics: "medical indications, preferences of patients, quality of life, and contextual features" (Jonsen et al., 2022, p. 8). Nurses and other healthcare professionals on the team gather information to answer the

TABLE 2-1 Four Topics Method for Analysis of Clinical Ethics Cases

Medical Indications

The Principles of Beneficence and Nonmaleficence

1. What is the patient's medical problem? Is the problem acute? Chronic? Critical? Reversible? Emergent? Terminal?
2. What are the goals of treatment?
3. In what circumstances are medical treatments not indicated?
4. What are the probabilities of success of various treatment options?
5. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?

Preferences of Patient

The Principle of Respect for Autonomy

1. Has the patient been informed of benefits and risks of diagnostic and treatment recommendations, understood this information, and given consent?
2. Is the patient mentally capable, and legally competent, and is there evidence of incapacity?
3. If mentally capable, what preferences about treatment is the patient stating?
4. If incapacitated, has the patient expressed prior preferences?
5. Who is the appropriate surrogate to make decisions for the incapacitated patient? What standards should govern the surrogate's decisions?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?

Quality of Life

The Principles of Beneficence and Nonmaleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life and what physical, mental, and social deficits might the patient experience even if treatment succeeds?
2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. What ethical issues arise concerning improving or enhancing a patient's quality of life?
5. Do quality-of-life assessments raise any questions that might contribute to a change of treatment plan, such as forgoing life-sustaining treatment?
6. Are there plans to provide pain relief and provide comfort after a decision has been made to forgo life-sustaining interventions?
7. Is medically assisted dying ethically or legally permissible?
8. What is the legal and ethical status of suicide?

Contextual Features

The Principles of Justice and Fairness

1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment of patients?

(continues)

TABLE 2-1 Four Topics Method for Analysis of Clinical Ethics Cases *(continued)*

2. Are there parties other than clinician and patient, such as family members, who have a legitimate interest in clinical decisions?
3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties?
4. Are there financial factors that create conflicts of interest in clinical decisions?
5. Are there problems of allocation of resources that affect clinical decisions?
6. Are there religious factors that might influence clinical decisions?
7. What are the legal issues that might affect clinical decisions?
8. Are there considerations of clinical research and medical education that affect clinical decisions?
9. Are there considerations of public health and safety that affect clinical decisions?
10. Does institutional affiliation create conflicts of interest that might influence clinical decisions?

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questions in each of the four boxes. The Four Topics Method facilitates dialogue between the patient–family/surrogate dyad and members of the healthcare ethics team or committee. By following the outline of the questions, healthcare providers can inspect and evaluate the full scope of the patient's situation and the central ethical conflicts. After the ethics team has gathered the facts of a case, an analysis is conducted. Each case is unique and should be considered as such, but the subject matter of particular situations often involves common threads with other ethically and legally accepted precedents, such as landmark cases that involve withdrawing or withholding treatment. Though each case analysis begins with facts, the four fundamental principles—autonomy, beneficence, nonmaleficence, and justice—along with the Four Topics Method are considered together as the process and resolution take place (Jonsen et al., 2022). In Table 2-1, each box includes principles appropriate for each of the four topics. To see an analysis of a specific case, go to the University of Washington Department of Bioethics and Humanities website under "Bioethics Tools."

Frustration, anger, and other intense emotional conflicts may occur among healthcare professionals or between healthcare professionals and the patient or the patient's surrogates. Unpleasant verbal exchanges and hurt feelings can result. Openness and sensitivity toward other healthcare professionals, patients, and family members are essential behaviors for nurses during these times. As information is exchanged and conversations take place, nurses need to maintain an attitude of respect as a top priority. If respect and sensitivity are maintained, lines of communication more likely will remain open.

ETHICAL REFLECTION

Civility involves treating others with courtesy and kindness, whereas incivility is consistent with exhibiting rudeness and disrespect. Incivility seems to be pervasive in society today. Acting with incivility involves a decision. Sometimes, people develop such an ingrained habit of acting without civility that being rude and disrespectful to others seems to be automatic. Using the five Rs of ethical nursing practice model in Box 2-8, consider ways that incivility among nurses and nursing students can be reduced.

The Healthcare Team

When patients and families are experiencing distress and suffering, often it is during times when decisions need to be made about risky

procedures or end-of-life care. Family members may want medical treatment for their loved one, whereas physicians and nurses may be explaining to the family that to continue treatment most likely would be nonbeneficial or futile for the patient. When patients are weakened by disease and illness and family members are reacting to their loved one's suffering, decisions regarding care and treatment become challenging for everyone concerned.

In caring for patients and interacting with their families, nurses sometimes find themselves caught in the middle of conflicts. Though nurses frequently make ethical decisions independently, they also act as an integral part of the larger team of decision makers. Many problematic bioethical decisions will not be made unilaterally—not by physicians, nurses, or any other single person. By participating in reflective dialogues with other professionals and healthcare personnel, nurses often are part of a larger team approach to ethical analysis. When a team is formally assembled and composed of preselected members who come together regularly to discuss ethical issues within an organization, the team is called an ethics committee. An organization's ethics committee usually consists of physicians, nurses, an on-staff chaplain, a social worker, a representative of the organization's administrative staff, possibly a legal representative, local community representatives, and others drafted by the team. Also, the involved patient, the patient's family, or a surrogate decision maker may meet with one or more committee members. See **BOX 2-9** for examples of the goals of an ethics committee.

Members of the healthcare team may question the decision-making capacity of the patient or family, and the patient's or family's decisions may conflict with the physician's or healthcare team's recommendations regarding treatment. Sometimes, a genuine ethical dilemma arises in a patient's care, difficult decisions must be made, difficult and unpleasant situations must be navigated, or no surrogate can be located to help make decisions for an incompetent patient. When these situations emerge, a team approach to decision making is helpful and in accordance with the IOM's (2003) call for healthcare professionals to work in interdisciplinary teams by cooperating, collaborating, communicating, and integrating care "to ensure that care is continuous and reliable" (p. 4).

At times, nurses do not agree with physicians', family members', or surrogates' decisions regarding treatment and subsequently

BOX 2-9 Goals of an Ethics Committee

- Provide support by providing guidance to patients, families, and decision makers.
- Review cases, as requested, when there are conflicts in basic values.
- Assist in clarifying situations that are ethical, legal, or religious in nature that extend beyond the scope of daily practice.
- Help clarify issues, discuss alternatives, and suggest compromises.
- Promote the rights of patients.
- Assist the patient and family, as appropriate, in coming to consensus with the options that best meet the patient's care needs.
- Promote fair policies and procedures that maximize the likelihood of achieving good, patient-centered outcomes.
- Enhance the ethical tenor of both healthcare organizations and professionals.

ETHICAL REFLECTION

In class or on your own, watch the HBO movie *Wit* starring Emma Thompson.

1. Apply as many concepts to the movie as you can from what you have read about and learned in this chapter and an earlier chapter 1.
2. Discuss your reflections with your peers in a classroom setting.

may experience moral suffering and uncertainty. When passionate ethical disputes arise between nurses and physicians or when nurses are seriously concerned about the action of patients' decision-making representatives, nurses are the ones who often seek an ethics consultation. It is within the rights and duties of nurses to seek help and advice from other professionals when they experience moral uncertainty or witness unethical conduct in their work setting. This action is a part of the nurse's role as a patient advocate.

KEY POINTS

- Bioethics was born out of the rapidly expanding technical environment of the 1900s.
- The four most well-known and frequently used bioethical principles are respect for autonomy, beneficence, nonmaleficence, and justice.
- Paternalism involves an overriding of autonomy in favor of the principle of beneficence.
- Social justice emphasizes the fairness of how the benefits and burdens of society are distributed among people.
- Ethical dilemmas involve unclear choices; not clear matters of right versus wrong.
- Nurses often experience a disquieting feeling of anguish, uneasiness, or angst in their work that is consistent with what might be called moral suffering.
- It is paradoxical that patients often must trust healthcare providers to care for them before the providers show evidence that trust is warranted.
- When acting as patient advocates, nurses try to identify patients' unmet needs and help to address these needs.
- Nurses may develop good critical thinking skills by thinking about their thinking.
- It is part of a nurse's role as a patient advocate to make or suggest an ethics committee referral when indicated.

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