

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)

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 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)

OBJECTIVES

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

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

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 that a mysterious disease called AIDS was at epidemic levels.

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

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,

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 particular 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, especially 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 do various ethical approaches relate to the Tuskegee study? (See Chapter 1)
4. Which procedures are in place today to prevent this type of unethical research?

and a commission was created to outline principles that must be used during research involving human subjects (National Institutes of Health, 1979). In 1976, to carry out their 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 Institutes of Health, 1979). The principle of beneficence, as set forth in the *Belmont Report*, is the rule

to do good. However, the description 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 seventh edition, 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 to 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, 2013). Each principle is considered to be *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 (2013) 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, 2013). 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; 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.

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 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 say *no* is part of exercising one's autonomy.

■ Informed Consent

Informed consent in regard to 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 (see **Box 2-2**). Though all conceptions of informed consent must contain the same basic elements,

BOX 2-2 Elements of Informed Consent

- I. Threshold elements (preconditions)
 - 1. Competence (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)

Source: Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press, p. 124.

the description of these elements is presented differently by different people. Beauchamp and Childress (2013) outlined informed consent according to seven elements. 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 be 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, consent may be verbalized, written, or implied by behavior. 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.

Legal Perspective

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 if nurses do not appropriately notify providers or supervisors about this deficiency.

It is neither ethical nor legal for a nurse to be responsible for obtaining informed consent for procedures performed by a physician (Dempski, 2009). Nurses may need to display the virtue of courage if physicians attempt to delegate this 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. 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, 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.

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. If a patient understands the treatment or procedure and allows the nurse to begin the nursing care, consent has been implied. Nursing procedures do not need to meet all of the requirements of informed consent if procedures are not risky or invasive (Dempski, 2009).

Legal Perspective

Assault and battery are two legal terms describing offenses against a person. Both 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.

■ 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, 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.

It is now expected that errors involving serious, preventable adverse events be reported to patients and other organizational reporting systems on a mandatory basis (IOM, 2000). Reporting near misses (i.e., errors that cause no harm to patients) are more controversial (Lo, 2009). Some professionals tend to avoid telling patients about near-miss errors since 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, Siegler, & Winslade, 2010).

Intentionally not disclosing information to a patient or surrogate is legal in situations of emergency or when patients waive their right to be informed. Respecting a patient's right *not* to be informed is especially important in culturally sensitive care. Other more legally and ethically controversial circumstances of intentionally not disclosing relevant information to a patient involve three

healthcare circumstances (Beauchamp & Childress, 2013). 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.

Invoking *therapeutic privilege* allows physicians to withhold information from patients if physicians, based on their sound medical judgment, believe “divulging the information would potentially harm a depressed, emotionally drained, or unstable patient” (Beauchamp & Childress, 2013, p. 127). There are various standards about what constitutes therapeutic privilege in different legal jurisdictions. Standards range from withholding information if the physician believes the information would have *any* negative effect on the patient’s health condition to withholding information only if divulging it is likely to have a *serious* effect.

Placebos, when used therapeutically, are inactive substances given to a patient in an attempt 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 a majority of patients, even when the patients know they are receiving an inert pill (Scuderi, 2011). Proponents of using placebos say the action is covered under a patient’s general consent to treatment, though the consent is not entirely informed. However, there is a general consensus that the therapeutic use of placebos is unethical (Jonsen et al., 2010) 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 when the nature of the research is behavioral or psychological and disclosure might seriously skew the outcomes of the research.

■ Patient Self-Determination Act

The Patient Self-Determination Act (PSDA), 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, to refuse or withdraw treatments, and to write advance directives. 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 are not lost in organizational admission processes, paperwork, and 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 in regard to 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 and observe patients' subtle cues signaling 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 in regard to 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], n.d.b, para. 2). The HIPAA Privacy Rule is a federal regulation designed to protect people from disclosure of their personal health information other than for the provision of health care and for other need-to-know purposes on a minimum necessary basis (HHS, n.d.c; HHS, 2003). 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, 2003, p. 3).

The Security Rules of the act operationalize the Privacy Rules. These rules contain standards addressing privacy safeguards for electronic protected health information (HHS, n.d.b). The rule is designed to "assure the confidentiality, integrity, and availability of electronic protected health information" (HHS, n.d.b, para. 2).

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. Other special health information privacy issues addressed by the HHS (n.d.a) include the following:

- Public health: There is sometimes a legitimate need to release medical information for the protection of public health.
- Research: Private information is protected, but processes are used to allow researchers to conduct well-designed studies.
- Emergency preparedness: As with other public health issues, access to protected information sometimes is allowed to facilitate emergency preparedness.
- Health information technology: The confidential maintenance and exchange of information via electronic formats is supported by the act.
- Genetic information: The Genetic Information Nondiscrimination Act (GINA) of 2008 identifies genetic information as health information and requires Privacy Rule modifications to ensure that no one is discriminated against in employment or for insurance coverage based on genetic information.

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 (2013), do make a distinction.

Nonmaleficence is the maxim or norm that “one ought not to inflict evil or harm” (Beauchamp & Childress, 2013, p. 152), 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. 152). As evidenced by these maxims, beneficence involves action to help someone and nonmaleficence requires “*intentional avoidance* of actions that cause harm” (p. 152). In addition to violating the maxim to not intentionally harm another person, some of the

BOX 2-3 Issues and Concepts Associated with the Principle of Nonmaleficence

1. Upholding standards of due care means abiding by the standards that are specific to one's profession; the acceptable and expected care a reasonable person in a profession would render.
2. Negligence is "the absence of due care" (Beauchamp & Childress, 2013, p. 155) and imposing a *risk* of harm; imposing an unintended careless risk of harm or imposing an intentional reckless risk of harm.
3. Making distinctions of and rules governing nontreatment and end-of-life decisions (Beauchamp & Childress, 2013, p. 158):
 - a. *Withholding* and *withdrawing* life-sustaining treatment
 - b. *Extraordinary* (or heroic) and *ordinary* treatment
 - c. *Sustenance technologies* and *medical treatments*
 - d. *Intended effects* and *merely foreseen effects* (rule of double effect)
 - e. Killing and letting die

Source: Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.

issues and concepts listed by Beauchamp and Childress as frequently involving or requiring the obligation of nonmaleficence are included 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, the need to avoid harm when deciding whether to provide treatment or to withhold or withdraw it, and considerations about rendering extraordinary or heroic treatment.

The distinctions included in Box 2-3 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., 2010), even though medical probabilities often are fairly clear.

The *rule of double effect* is mentioned in Box 2-3. 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 has to 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; see Appendix B). The terms *killing* and *letting die* raises issues of legality, ethics, homicide, suicide, euthanasia, acts of commission and omission, and active–passive distinctions, which are beyond the scope of this chapter.

■ 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 one that 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, the concept of the slippery slope sometimes 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, 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 2014 no slide toward the legalization of nonvoluntary euthanasia has occurred in the United States. Opponents of slippery slope arguments believe people proposing this type of argument mistrust people's abilities to make definitive distinctions between moral/legal and immoral/illegal issues and to exercise appropriate societal controls.

Focus for Debate

In 2015, the United Kingdom began the process to pass a '3-parent babies' law. If passed, the law will legalize in vitro-fertilization using the DNA from three people to prevent mitochondrial diseases in babies. Search the Internet and check the status of this law. Is a law like this one a slippery slope issue?

Beneficence

The principle of beneficence consists of performing deeds of "mercy, kindness, friendship, charity and the like" (Beauchamp & Childress, 2013, p. 202). *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 2-4**.

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 to 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; see Appendix B) to have their patients' interests and well-being as their primary concern. Therefore, though there sometimes are limits to the good nurses can do, nurses have a more stringent obligation to act according to the principle of

BOX 2-4 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.

Source: Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press, p. 204.

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.

■ 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.

Legal Perspective

Motorcycle helmet laws vary among states from no law, a law based on age, to 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?

Two types of paternalism are listed in **Box 2-5**. 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 that patients should not be given bad news, such as a terminal diagnosis.

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

BOX 2-5 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, substance abuse, and addiction.
 - Hard paternalism: “Interventions intended to prevent or mitigate harm to or to benefit a person, despite the fact that the person’s risky choices and actions are informed, voluntary, and autonomous” (Beauchamp & Childress, 2013, p. 217).
1. A patient is at risk of a significant, preventable harm.
 2. The paternalistic action will probably prevent the harm.
 3. The prevention of harm to the patient outweighs risks to the patient of the action taken.
 4. There is no morally better alternative to the limitation of autonomy that occurs.
 5. The least autonomy-restrictive alternative that will secure the benefits is adopted (p. 222).

According to Beauchamp and Childress (2013), the following is a summary of justifiable reasons to practice hard paternalism (p. 222):

Source: Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.

is entitled to, and who will pay for healthcare costs. Remember, however, justice is one of Plato’s cardinal virtues. This means that justice is a broad concept in the field of ethics and is 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 have to 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

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.
- Alleviating global poverty.
- Working as a nurse during a highly lethal influenza pandemic.
- Defending the rights of immigrants.

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 to maximize 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 and hunger.

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 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 not be likely to try 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 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.

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.

Focus for Debate

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

■ The Patient Protection and Affordable Care Act

Signed into law by President Obama on March 23, 2010, the Affordable Care Act (ACA) is intended to enact comprehensive healthcare reform in the United States, including improving quality and lowering healthcare costs, providing greater access to health care, and providing new consumer protections (HHS, 2014). The ACA HHS website indicates that the act puts 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/HealthCare website at <http://www.hhs.gov/healthcare/index.html>.

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 in regard to the ACA:

- Will 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 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.
- Will 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 will prompt more people to use resources indiscriminately rather than rationally. This concern is founded somewhat on a slippery slope argument. This position cannot be supported or refuted until data is gathered.
- 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

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 a number of 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?
- Will the ACA provide a more efficient system of health care?
- Will 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?
- Will 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?

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, i.e., an entitlement. (Pence, 2015, p. 347)

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. In 2012 the U.S. Supreme Court upheld the ACA.

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.

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 are in need of 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 are in need of care patients have no option but to trust nurses and other healthcare professionals.

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

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

Ethical Reflection

Search the Internet for the poem “The Operation” by Anne Sexton. Read the poem reflectively and do the following:

1. Analyze the story, symbolism, and feelings conveyed 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 in regard to the circumstances of how people look, behave, and express themselves when they are being watched by others or when they 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 stop and 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 what the person is capable of doing and wants to do in the present.

A lack of or loss of capability is frequently an issue for consideration when caring for patients such as children, elders, and physically and mentally disabled persons. 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 based on urgent need without prejudice, 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's moving from the patient to the healthcare system rather than moving from the nurse's 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, that patients are provided with the information needed to make informed decisions, and that collaboration is used to increase the accessibility and availability of health care to all patients who need it. The ICN (2012), in its *Code of Ethics for Nurses*, affirms that the nurse must share "with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations" (p. 2).

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 if they find themselves in imperfect situations that are morally unsatisfactory or when 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 she 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 oneself 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, and it is incumbent upon nurses to habitually act in virtuous ways, that is, to exhibit habits of excellent character.

Ethical Reflection

Have you experienced moral suffering during your work as a nurse or student nurse? Explain.

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 to 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.

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 leading 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 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.

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

Focus for Debate

Abortion is legal, but many people believe it is not ethical. Does the legality of abortion affect whether it presents an ethical dilemma?

when people believe they face a dilemma, they are facing a “false dilemma”; the person only needs 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 or not Heinz should have done this. Did Heinz face a dilemma? Weston discussed the Heinz 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 health care 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?” are ever-present normative considerations 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 either 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 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 are able to 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,

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.

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.

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 is also 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 noticed that a large number of 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, non-threatening 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?" with regard to 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

Focus for Debate

Do members of the nursing profession focus too much on nursing virtues and caring, thus minimizing a focus on nurses' scientific knowledge and thereby hurting nursing's public image?

Jersey governor and 9/11 Commission chairman, Thomas Kean, made a statement with regard to the findings about the probable causes of the failure to prevent the terrorist attacks on September 11, 2001 (Mondics, 2004). 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; program planning; program implementation; and program evaluation. When assuming this key leadership role, nurses continually make choices and decisions that may affect the well-being of both individuals and populations. 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 sometime 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 though 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 the 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, to ask good questions, to challenge the status quo, and to be continual learners (see **Box 2-6**). There is no one model of reflection and decision making that can provide healthcare professionals with an algorithm for ethical practice. However, there are a number of models professionals can use to improve their skills of reflection and decision making during their practice. The Four Topics Method, discussed below, is an example of reflection-*in*-action.

Ethical Reflection

Reflect on a challenging, personal, ethical situation that occurred during your nursing practice or personal life.

■ The Four Topics Approach to Ethical Decision Making

Jonsen and colleagues' (2010) 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., 2010).

This case-based approach allows healthcare professionals to construct the facts of a case in a structured format that facilitates critical thinking about ethical

BOX 2-6 The Five Rs Approach to Ethical Nursing Practice

- 1. Read:** 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:** 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:** 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:** 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.
- 5. Respond:** 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

Insight
Practical wisdom

Moral virtues

Compassion
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 the right 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 persons' 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.

problems. Cases are analyzed according to four topics: “medical indications, patient preferences, quality of life, and contextual features” (Jonsen et al., 2010, p. 8). Nurses and other healthcare professionals on the team gather information in an attempt to answer the questions in each of the four boxes. The Four Topics

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?

Patient Preferences

The Principle of Respect for Autonomy

1. Has the patient been informed of benefits and risks, 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?
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 regarding changes in treatment plans, such as forgoing life-sustaining treatment?
6. What are plans and rationale to forgo life-sustaining treatment?
7. What is the legal and ethical status of suicide?

(continues)

TABLE 2-1 Four Topics Method for Analysis of Clinical Ethics Cases (continued)**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?
2. Are there parties other than clinicians and patients, such as family members, who have an 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 scarce health resources that might affect clinical decisions?
6. Are there religious issues that might influence clinical decisions?
7. What are the legal issues that might affect clinical decisions?
8. Are there considerations of clinical research and education that might affect clinical decisions?
9. Are there issues of public health and safety that affect clinical decisions?
10. Are there conflicts of interest within institutions and organizations (e.g., hospitals) that may affect clinical decisions and patient welfare?

Source: Jonsen et al., 2010

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 are able to inspect and evaluate the full scope of the patient's situation and the central ethical conflict. 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 involved 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., 2010). 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 <http://depts.washington.edu/bioethx/tools/cecase.html>.

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.

■ The Healthcare Team

When patients and families are experiencing distress and suffering, it often 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, while 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 particular 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 are often part of a larger team approach to ethical analysis. When a team is formally assembled and is composed of preselected members that 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 2-7** 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 is 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 may experience moral suffering and uncertainty. When passionate ethical disputes arise between nurses

BOX 2-7 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.
- Provide assistance 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.

Source: Pozgar, G. D. (2010). *Legal and ethical issues for health professionals* (2nd ed.). Sudbury, MA: Jones and Bartlett, pp. 142–143.

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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