CHAPTER 11
Ethics and Health

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A different way of thinking about right and wrong actions may be needed in working with aggregate populations in the community. The situation becomes more complex when we attempt to weigh individual rights and privileges against what is best for the larger group.

It has become appallingly obvious that our technology has exceeded our humanity.

—Albert Einstein

A state legislature allotted its state health department $750,000 to match Ryan White federal funding for medication sufficient to treat 20 patients with acquired immune deficiency syndrome (AIDS). However, there were 100 patients who needed the help. Public health nurses in each district were asked to select patients for the medication program.

A terminally ill cancer patient who is in great pain begs the nurse for more medication than the physician has ordered. What should the nurse do?

A man was diagnosed and treated for a venereal infection by his family nurse practitioner. He agreed that his wife should also be treated but he did not want her to know that he acquired the disease from a prostitute and infected her. He asked the nurse practitioner if there was any way to avoid sharing this information.

When faced with situations like these, it sometimes feels like there are no "right" answers. What are your reactions to the three ethical dilemmas? What other information would be helpful to know about these situations to make a decision?

CHAPTER FOCUS

Virtue or Character Ethics

Principle-Based Ethics: Developing Moral Rules
- Utilitarian Theories: Doing the Most Good for the Most People
- Deontological Theories: Balancing Rights and Obligations
- Justice in Health Care
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Ethics of Care

Ethical Problems Faced by Community Nurses: The Research

Ethical Decision Making

Service Learning: Discovering the Self and Developing Community Values

QUESTIONS TO CONSIDER

After reading this chapter, you will know the answers to the following questions:

1. What is bioethics, and how is it important to the community nurse?
2. What is the ethics of virtue, and what part do virtues play in the practice of nursing?
3. What is meant by principle-based ethics?
4. How does Kant's deontological approach differ from Mill's utilitarian approach?

5. What role does each of the four major ethical concepts— beneficence, nonmaleficence, autonomy, and justice—play in community nursing practice?
6. How can health care resources be distributed in a fair manner?
7. How does the ethical theory of care differ or agree with other theories?
8. What information does the nurse need to make ethically based decisions?
9. What is service learning, and how does it apply to community health?

KEY TERMS

Autonomy	Consequentialism	Ethical dilemma	Service learning
Benevolence	Deontological	Ethics	Trustworthiness
Bioethics	Discernment	Integrity	Utilitarianism
Casuistry	Ethic of caring	Justice	Virtue ethics
Compassion	Ethical decision making	Nonmaleficence	

One of the dilemmas of today's health care debate is that medical ethics, as currently structured and interpreted, is bad public policy and actually counterproductive to the total well-being of society.

—Richard Lamm, Executive Director, Center for Public Policy
and Contemporary Issues, and former governor of Colorado

THE SITUATIONS WE encounter as health care professionals may be complex and puzzling dealing with serious issues of well-being, life, and death. Our early experiences are usually of little help in guiding our actions in such complex situations. The philosophical discipline of **ethics** is the study of how we should behave, or how to determine the right thing to do in our interactions with others. **Bioethics** is the common name for the study of ethics as it relates to health and the moral problems that arise as a result of advances in health technologies and our increasing ability to do more to treat illness and prolong life. The theories resulting from ethical study provide a guide to examining ethical situations and to articulating preferred ways of living and behaving as health care practitioners. We must, however, remain aware that differences of opinion exist among those well versed in bioethics regarding which theories best fit which cases, as well as what kind of role character development plays in preparation for acting ethically in the community.

As our understanding of the universe, the nature of human behavior, and societal relationships has increased or changed, theories about ethical behavior have been modified and new theories developed. One essential difference in the various approaches to ethical decision making has to do with the target of the action. For whom or for what are we interested in doing the right thing—ourselves, a co-worker, an individual patient, a family, an organization, a community, a nation, or the world? Unfortunately, what may seem to be the right thing to do for one person or group may not be the right thing for another. A situation characterized by conflicting rights or obligations is known as an **ethical dilemma**.

Because of the variety of settings in which nurses practice and the philosophical assumption of the nursing community that nurses care for the whole person, nurses are often involved in all aspects of the patient's life as it relates to health. Bishop and Scudder (1990) point out that a major characteristic of nursing is that nurses practice "in-between." By this, they mean that in addition to giving direct care to the patient, nurses must manage and coordinate other aspects of the patient's care. This management includes advocating for the patient with the physician and other health care providers, interpreting the patient's needs to the agency, and interpreting agency policy and other constraints to patients and families. For a community health nurse, it may also mean advocating for agencies and policies in the political arena.

For the nurse practicing in the community, the community itself is another interested party in the patient's health care. Fry points out that in addition to their moral accountability for individual patients, community health nurses have a moral accountability for "how they provide health services to maximize total net health in population groups" (1996, p. 108).

A different way of thinking about right and wrong actions may be needed in working with aggregate populations. The situation becomes more complex when we attempt to weigh individual rights and privileges against assessments of what is best for a larger group. Horn (1999) suggests that considerations that compete in our conscientious ethical leanings and our ethical decision procedures include justice in distribution, the patient's comfort level or happiness, the patient's wishes, the expense of services, the patient's responsibility in acquiring a condition, and the social role of the patient.

One approach to increasing competence in dealing with ethical matters is to begin with clarification of your own values and identifying and understanding the values by which other people live. The cultural competence required for expert nursing care is a specific ethical demand on members of the profession to know and respect the values of others. Steele and Harmon (1983) and Uustal (1991) have developed strategies to aid in values clarification. The steps in the clarification process help people discover which values they hold and how strongly they hold them in relation to others. Values are often the result of years of consciously seeking information and weighing the importance of one point of view against another. However, they are also simply adopted from family tradition, religious teaching, or modeling people whom we admire without much reflection.

Over the millennia, philosophers, theologians, and others have attempted to formulate principles and rules that will guide us in ethical behavior. This chapter presents

Everywhere, it appears, health care workers consider that the 'best' health care is one where everything known to medicine is applied to every individual by the highest trained medical scientist in the most specialized institutions.

—M. Charlesworth, past director of the
World Health Organization, 1993

Dr. Pat Kurtz, chapter author, counseling an elderly patient about a living will.

some of the basic principles of classical ethical theories (virtue ethics, deontology or formalism, and utilitarianism or consequentialism), as well as more recent formulations of biomedical ethics and care ethics. It includes a special focus on the justice issue of distribution of care and on the value systems that influence our national agendas for health care. Finally, research related to ethical dilemmas identified by community health nurses will be reviewed and frameworks for **ethical decision making** presented.

❝ *The ultimate measure of a man is not where he stands in moments of comfort and convenience but where he stands at times of challenge and controversy.* ❞

❝ *Our lives begin to end the day we become silent about things that matter.* ❞

—Martin Luther King, Jr.

Virtue or Character Ethics

One of the earliest philosophical approaches to correct behavior was that of **virtue ethics**. According to this approach, if a person has a "good" character, that person will behave ethically as a matter of course. Virtue ethics is based on the writings of the Greek philosopher Aristotle (384–382 BCE). Aristotle (1975) believed that there was general agreement that everyone has a "life goal" and that ultimate life goal was "happiness." Although each person has a different definition of happiness, Aristotle believed that happiness is achieved by what he called "excellence in performing rational activities" (thinking), which includes "excellence in choosing."

Behavioral choices lie on a continuum between ultimate extremes. Gluttony or self-denial might be the two extremes of a continuum representing eating or any other behavior relating to psychological or physiological needs. Foolhardiness and cowardice might be the extremes of a risk-taking continuum. Aristotle argued that the best choices lie between the two extremes, preferably somewhere in the middle, which he called the *golden mean*. The person who selects and acts on these middle-ground choices is virtuous. A person who does so with a pattern of consistency born of practice is thought to have good character.

Aristotle believed that becoming a virtuous person was a matter of habit and could be learned over time. The more one acts virtuously, the stronger the character trait becomes. In the throes of a crisis, character traits come to the fore and are more likely than relying on sudden decision making to result in good outcomes. From this standpoint, part of becoming a "good" nurse would require that students should practice a life of moderate choices based on those choices they believe an ethically ideal role model would make. Continuing to practice in this vein is believed to foster good habits that have the best likelihood of leading to right actions in professional practice. That is, the virtuous nurse would simply be disposed to do the ethically right thing, rather than

having to reason to an ethical solution by some procedure. The word *ethics* actually stems from the Greek word *ethos*, which means "well-developed habits."

Like many other experiences in life, a given behavior may or may not be considered virtuous, depending on the culture of the individual. Honesty is often considered a virtue. However, if you belong to a criminal community or to a poverty-stricken family or community, honesty may not be valued in the same way it is in a community of middle-class property owners. Likewise, not all virtues are ethical in nature. Cheerfulness may be considered a virtuous social trait, but it is ethical only when displayed within an ethical situation. Even a right action is not ethical by itself, according to Aristotle, unless the action comes from ethical motivation. In other words, to be considered virtuous, not only must the behavior be the right action, purposefully done, but it must also come from an ethically appropriate inner urge to do the right thing. Box 11-1 describes characteristics of virtue ethics.

Characteristic of certain roles, occupations, and professions are expectations that its practitioners will have character and virtues beyond those of other people. In the case of nursing, it is expected that nurses will be (possess the virtue of) caring and will express that caring in all aspects of patient–nurse interaction. As a virtue, caring may be considered a mean between extremes on a continuum of attention to and feeling for others. At the one extreme would be rejection and callousness; at the other extreme would be over-involvement and indulgence. From a patient's point of view, caring includes or implies other virtues. For example, if nurses are caring, they are also trustworthy and can be relied upon to give fitting priority to the patient's welfare.

The Florence Nightingale Pledge identifies some virtues that were expected of nurses in the past. These virtues include purity, obedience, loyalty, and willingness to assume the handmaiden role to the physician (Davis & Aroskar, 1991). Changes in the societal expectations of the role of women in general and expectations from within nursing have devalued some of these historical virtues and replaced them with virtues of assertiveness, loyalty to and advocacy for the patient, and willingness to take appropriate risks.

> ## BOX 11-1
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> ### Virtue Ethics: Aristotle
> - The ultimate goal of life is to achieve happiness, which comes from excellence of thinking.
> - An important aspect of excellence of thinking is excellence of choosing virtuous action—the golden mean.
> - A virtuous action is moral only when it is done from a motivation to do the right thing.
> - Virtue, for those of good character, is learned over time by the practice of acting in virtuous ways.
> - Virtues are partly discerned from observing instances of sustained exemplary behavior by role models.

It is not uncommon for nurse educators and other nurses to question the virtuousness of today's nursing students and novice nurses. They complain that some nurses are joining the profession for its high salaries and security and do not show the ethical character traits of caring and the strict honesty that they believe are required of nurses.

Beauchamp and Childress (1994) have identified four virtues that they consider primary to the ethics of health professionals: compassion, discernment, trustworthiness, and integrity.

Compassion, a notion related to caring, includes a concern for others and an awareness of their pain or suffering. The compassionate person is disposed to respond with appropriate feelings of sympathy and mercy, as well as a desire to help decrease pain and other suffering. Ethically, being disposed to show these feelings also may be a critical factor in a patient's perception of being cared for.

While compassion has a strong emotional component, **discernment** is an intellectual trait. The discerning person is able to take decisive action based on insight resulting from a history of clear judgment and understanding. He or she is able to make ethical judgments without being unduly influenced by other personal or political factors. The person sees to the heart of the matter without the bias of personal involvement or personal feelings, without the common ethical flaw known as "conflict of interest." The discerning person is able to see what needs to be done, when, and in what way in situations involving ethical considerations.

Trustworthiness is a character trait that gives other people confidence that an individual will consistently do the right thing for the right (ethical) reasons. Beauchamp and Childress believe that the presence or lack of trustworthiness may be the most influential factor in whether a relationship continues between a patient and a caregiver. Importantly, in national polls, nurses have been consistently rated by the public as being the most trustworthy group among professionals.

Integrity, according to Beauchamp and Childress, exists when an individual habitually behaves in a way that is consistent with that individual's core values and beliefs. Persons of integrity, so to speak, "walk their virtuous talk." Integrity may be disturbed when the individual must compromise some beliefs and values. This compromising often results in a tension known as moral distress. People are said to have integrity when they are known not to compromise their ethical principles. We are more likely to trust people who we believe have integrity.

Principle-Based Ethics: Developing Moral Rules

In principle-based approaches to ethics, the right or ethical action is determined not by the virtues (or habits) of individuals or authoritative tradition, but rather by the support of a set of beliefs developed by careful reasoning. Such beliefs include ideas about who has what kinds of rights and which rights or obligations have priority over other rights and ob-

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ligations. For example, who has the right to make decisions about a patient's health care, and in what ways are health care providers obligated to support a decision with which they disagree? The two major principle-based approaches are utilitarianism and deontology.

Utilitarian Theories: Doing the Most Good for the Most People

The primary belief of people who have adopted the utilitarian position is that the most ethical action is the one that results in the greatest good (happiness) for the greatest number. A corollary to this notion would be that the best action is the one that causes the least harm to the fewest people. The philosopher cited most frequently as a proponent of **utilitarianism** is John Stuart Mill (1806–1873).

To a utilitarian, the important thing is not so much your good will toward others, but rather the consequences that result from your action. (Utilitarianism is also known as **consequentialism**.) Determining which action to take requires that all possible actions in the situation and the potential outcomes of each be examined for every person or group who may be involved. After the different outcomes are weighed and balanced, the action that leads to the best outcome for the most people is selected.

The utilitarian approach has obvious limitations. The first that may come to mind is the problem of how we can know what the outcomes will be for all the persons involved, because many factors beyond our control—or even beyond our knowledge—influence outcomes. Another problem arises when the preferred action and/or outcome is itself unethical. An example would be falsifying records in a home health agency so that the insurers will continue to pay for visits to otherwise ineligible patients. If the purpose of the falsification was to continue needed services to patients who would otherwise not receive them, the consequence is positive for the patient; however, the means are still unethical (as well as illegal). Recognizing this possible misuse of the theory as a rationalization for unethical behavior, Mill (1859/1871/1993) acknowledged that some behaviors were inherently unethical and could not be condoned, no matter what the favorable outcome. He specifically cited slavery as an example.

A more relevant issue in our time might be the use of migrant labor at pay rates below minimum wage and without decent provisions for living to produce cheaper food for the U.S. larger population. To avoid the misuse of this ethical approach, commonly expressed as "the ends justify

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the means," there must be general agreement about the ethical appropriateness of the proposed action and possible outcomes.

Another common criticism of the utilitarian approach is that it may not be practical for the average person. The principle of maximizing benefit for the greatest number may place the individuals making the decision in a position of always having to sacrifice their own preferences for the greater good. This self-sacrifice may be too difficult for the average person and raises questions about what the limits of our obligation to maximize benefit in that way are and whether it is even possible to make fair decisions in situations in which we may either be benefited or harmed. For example, suppose you are asked to support legislation that would provide increased health benefits for you and your family. After examining the proposed legislation, you realize that it will exclude many needy people who are benefiting from current legislation. In this instance, opposition to the proposed legislation would benefit more people, but at your expense.

The utilitarian approach is also criticized because it appears to give undue advantage to the majority population. For example, legislation that mandates increased health benefits (e.g., mammography) for participants in a health maintenance organization (HMO), Medicaid recipients, or those who have other private insurance will benefit a large number of people. At the same time, it excludes a minority who has no insurance and who may have more need for the services, but lacks the ability to pay for them. The criterion of justice (discussed in detail later)—so important in other approaches—may be missing from the utilitarian approach. Box 11-2 lists the major descriptors of utilitarianism/consequentialism.

A major area in which utilitarianism aids decision making is in public policy development, wherein it is often referred to as *cost–benefit analysis*. It is the presumed goal of policy makers that whatever money is appropriated or whatever regulations are adopted will further the general good of society. Developing public policy requires the careful examination of all possible options and the probable consequences of each. It is not uncommon that legislation is passed with good intentions, only to find later that a group of people has been left out, that the new legislation conflicts with other important practices, or that it encourages poor or fraudulent practices. It is important that nurses be at the

BOX 11-2

Utilitarianism/Consequentialism
- The major determinant of ethical behavior is that it provides the most benefit to the most people or the least harm to the fewest people.
- The decision to act must be based on a careful examination of all possible actions in the situation and the possible consequences of each action.
- Regardless of consequences, actions themselves must be deemed to be ethical.

"A cynic is a man who, when he smells flowers, looks around for a coffin."

—*H. L. Mencken*

⚖ ETHICAL CONNECTION

Stason and Weinstein studied the cost-effectiveness of screening and treating hypertension using data from the Framingham longitudinal study and results of other hypertension studies. They projected various models of cost from initial screening to long-term treatment, considering such factors as dropout rates; nonadherence to medication; side effects; probability of more expensive events, such as stroke and myocardial infarction; and age. They found that it is more cost-effective to fund programs designed to increase adherence to the treatment regimen for those already in treatment than to institute screening for new cases. They also found that it is more cost-effective if hypertensive men start treatment when they are young, but women begin when they are older. The recommendation was that *if* screening is instituted, the focus should be on young men and older women.

What are the disadvantages to this utilitarian approach? Do you agree or disagree with this approach? ⚠

Source: Stason, W. B., & Weinstein, M. C. (1977). Public health rounds at the Harvard School of Public Health: Allocation of resources to manage hypertension. *New England Journal of Medicine, 296*(3), 732–739.

decision-making table to provide data about these options and consequences from their perspectives as caregivers and advocates. Further information about how to be effective in these activities is found in Chapter 8.

▪ Deontological Theories: Balancing Rights and Obligations

Ethical theories categorized as **deontological** uphold the position that whether an action is ethical depends on the action itself—principally the motivational basis for the action. The word "deontological" was originally meant to differentiate an ethic of duty from the more utilitarian ethic of consequences. Today, the term includes any mixture of considerations that emphasizes other than consequences.

Immanuel Kant (1724–1804) is the philosopher who proposed the basis for our major theory of deontological ethics in his attempt to elaborate a rationale for ethical behavior based on pure reason, rather than tradition or authoritative pronouncement. Kant (1997) proposed two foundational principles, or rules, that he called "categorical imperatives" or unconditional "ethical laws." "Law" here means the generalized reason for an action, which would hold universally and which everyone must follow. If a rule meets that criterion, then it will always be true for every similar instance, and the individual is therefore obligated to follow the rule in every instance.

For example, you might want to determine whether it is ethical to lie to a patient about a diagnosis or prognosis. Is lying ethical? Based on Kant's procedures to determine the imperative, you would first determine whether lying could be an acceptable ethical behavior. Rationally, you would have to conclude that it could not; otherwise, no relationships that required trust could be developed. Therefore, lying is not ethical and is not acceptable in any situation. "Never lie" would be a categorical imperative. It could be argued, however, that some health care patients are special cases and that telling them the truth might cause psychological harm. Therefore, it is more ethical to lie than to risk causing harm. The imperative that one should never lie would have to be rejected or, at least restated, if this is thought to be true.

Got an Alternative?

As more people seek out alternative health practices, nurses face a challenge. Nurses are often less familiar about these nontraditional treatments, so how can they practice in an ethical manner when their values are based on traditional medical treatment?

Kant's second principle is that everyone should be treated as ends and not means to an end. Modern versions of deontological theory all include this second imperative in rules related to respect for individuals (the principle of autonomy). Box 11-3 describes deontological ethics according to Kant.

We have many examples of other approaches to this rule-based ethics. Of specific interest are theories of justice, notably those of Rawls and Nozick, which will be discussed later. Western civilization has had the Judeo-Christian ethic, which includes the Ten Commandments, which are universal rules proposed for adherents of those religions. Other religions have similar rules for behavior. Codes of ethics for professional groups are also examples of this approach.

Nurses rely to a large extent for guidance in ethical matters on the American Nurses Association *Code of Ethics* (ANA, 2001) and accompanying interpretive comments. This code focuses on professional responsibilities and on obligations of the nurse toward all patients. It clearly includes the community as a type of patient and the role of the nurse in the community. It does not go into detail about ethics with populations but is clearly consistent with the recently

> **"** *A lie can travel halfway around the world while the truth is putting on its shoes.* **"**
>
> —Mark Twain

published code of ethics for public health team members. The "Principles of the Ethical Practice of Public Health" are listed in the Cultural Connection feature.

Modern bioethics is another form of the deontological approach to ethics. Two events have influenced the development of modern bioethical theory: the medical experiments of German physicians during World War II (Davis & Aroskar, 1991) and the increasing development and use of technology in medicine (Beauchamp & Childress, 1994). In the first instance, interest in gaining new knowledge that would be helpful in the Nazi war effort, together with a disrespect for certain groups of people (e.g., Jews, Gypsies, mentally handicapped), motivated the Nazi doctors to perform experiments that were excruciatingly painful, degrading, and murderous. Revelation of these experiments at the Nuremberg trials following the war shocked the world community and increased awareness of humankind's capacity for inflicting harm. Further awareness and shock came with the revelation of inhumane research being conducted in the United States. Some, like the Tuskegee syphilis study being conducted on Southern African American men, was supported by the U.S. Public Health Service. The results of these and other revelations were a series of national and international codes of ethics for the conduct of research.

The introduction of increasingly more sophisticated technology over the last 40 years has enabled health care

BOX 11-3

Deontological Ethics: Immanuel Kant
- Individuals establish their own moral rules based on the criterion that the generalized intention of their action could apply to everyone—that is, could become a "law."
- The rules apply to every similar situation.
- People must be treated as ends and not means (given respect as autonomous persons).

🔨 ETHICAL CONNECTION

In 1932, the U.S. Public Health Service funded research to study the natural course of syphilis, a disease that at the time had no known, reliable treatment. Subjects for that study consisted of a group of 200 Black men who were infected with the disease and 100 Black men who were uninfected from the small area of Tuskegee, Alabama. The study continued for 40 years, during which time the infected population became more ill and had a much higher mortality rate than the uninfected control group. By the 1940s, it was found that penicillin was an effective treatment; however, none of the men were given the antibiotic. Many of the men did not know that they were subjects of a research study, were not told that penicillin would help them, and faithfully continued to appear for the periodic exams, believing that they were being treated. Articles reporting on the study were published in medical journals and, in addition to the nurse and physicians involved, many physicians from the Tuskegee medical center and around the state knew about the work. It was not until the project was exposed in 1972 in a Washington newspaper that the public became aware and expressed outrage about it. At this point the study was finally discontinued.

Source: Brandt, A. M. (1978). Racism and research: The case of the Tuskegee syphilis study. *Hastings Center Report, 8*(6), 21–29.

providers to perform complicated surgical procedures, such as heart bypass and organ transplants; to keep premature infants alive; to identify genetic abnormalities in a fetus; and to maintain nutrition, hydration, and respiration in patients in irreversible coma. In the struggle to find the right actions in these and other situations, solutions for many ethical dilemmas were eventually sought from the courts.

ENVIRONMENTAL CONNECTION

Toxic waste dumps and other contaminants that affect people's health are often located near impoverished and vulnerable populations. What are the ethical implications of this practice and how does it reflect government accountability for safeguarding the health of all its citizens?

> *An eye for an eye makes the whole world blind.*
> —Mahatma Gandhi

> *Be kind, for everyone you meet is fighting a hard battle.*
> —Plato

Beauchamp and Childress (1994) have identified four concepts they believe to be essential to a theory of modern bioethics: **autonomy** (respect for persons), **nonmaleficence** (refraining from harm), **benevolence** (doing good), and **justice** (fair distribution of burdens and benefits). Other principles, such as sanctity of life, truthfulness, confidentiality, and gratitude, are sometimes added to this list by other ethicists (Burkhardt & Nathaniel, 1988; Uustal, 1993). Some ethicists prioritize these principles by saying, for example, that when there is a conflict between principles, the principle of autonomy will take precedence. Others believe that none of the obligations that arise in the course of relationships is primary. Each principle may be overridden in a situation of conflict with another ethical obligation.

Respect for the Autonomy of the Individual

Beauchamp and Childress define personal autonomy as "personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding" (1994, p. 121). Having respect for an individual's autonomy means understanding and acting on the belief that people have the right to make decisions and take actions based on their own beliefs and value systems.

The concept of autonomy is further elaborated by arguing that respect for autonomy is not just the negative action of not interfering, but also includes the obligation to take positive actions to promote the individual's capacity to be autonomous. An example of a positive action might be to provide care that will restore an individual's capacity to think clearly after a period of confusion. Working with family members to limit their pressure on the patient for a particular decision and providing information to an

CULTURAL CONNECTION

Principles of the Ethical Practice of Public Health, Version 2.2

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

The development and dissemination of the "Principles of the Ethical Practice of Public Health" is funded primarily by the Centers for Disease Control and Prevention through the Public Health Leadership Society (PHLS). The Center for Health Leadership and Practice, Public Health Institute, is acknowledged for its role in the initial development of the Principles. PHLS also acknowledges the work of the members of the original PHLS Ethics Work Group (responsible for drafting the code) and the current members of the PHLS Standing Committee on Ethics.

individual or community group that needs to make a good decision regarding health care are other examples. Principles of privacy and confidentiality both are derived from respect for autonomy, as is the principle of informed consent, which refers to the patient's agreement to undergo a medical or nursing treatment or be a research subject.

Nonmaleficence

"First, do no harm" has been part of the Hippocratic Oath taken by physicians for centuries and has been a cornerstone of ethical practice in medicine and nursing. For some (Frakena, 1973), the principles of nonmaleficence and beneficence are the ends of a continuum relating to harm and obligations to help. In this context, the principle with the highest priority of obligation is that of inflicting no harm. The second priority is that a person should prevent harm. The third priority is that of removing harm. The fourth priority is that of doing or promoting good. Rules that may be said to emerge from the nonmaleficence principle include not killing, not causing pain or suffering, not incapacitating others, not offending others, and not depriving others of the "goods of life." Major ethical issues related to nonmaleficence deal with treatments used to prolong life, such as intubation and artificial feeding.

> *Don't go around saying the world owes you a living. The world owes you nothing. It was here first.*
>
> —Mark Twain

Communitarian Ethic*

> *There is no power for change greater than a community discovering what it cares about.*
>
> —Margaret Wheatley

Because of the relationships involved, a community has a "moral nature" as compared to the nature of a population. *Communitarian ethics* is based on the position that "everything fundamental in ethics derives from communal values, the common good, social goals, traditional practices, and cooperative virtues" (Beauchamp & Childress, 2001, p. 362). Communitarian ethics is applicable to moral relationships within any type of community, both large and small. As an ethical approach, it is distinguished because the epicenter of communitarian ethics is the community rather than beginning from the point of any one individual (Wildes, 2000). Populations in general, and moral communities in particular, are also the starting points for community nursing.

Some ethicists have tried to draw a strong distinction between ethical approaches that emphasize individualism and autonomy as differentiated from communitarian ethics, which emphasizes a common good. However, it is reasonable to assume that people can be interested in both their own well-being and the common good of the communities to which they belong. The value of considering communitarian ethics lies in the benefit that can be gained from illuminating and appreciating the relationships and in-

*This section was authored by Dr. Karen Rich and adapted from the following source: Rich, K. L. (2005). Community and public health nursing and leadership ethics. In J. B. Butts & K. L. Rich (Eds.), *Nursing ethics across the curriculum and into practice* (pp. 203–230). Sudbury, MA: Jones and Bartlett.

> *The Buddhist Avatamsaka Sutra contains a story about how all perceiving, thinking beings are connected in a way that is similar to a universal community. The story is about the heavenly net of the god Indra. 'In the heaven of Indra, there is said to be a network of pearls, so arranged that if you look at one you see all the others reflected in it. In the same way each object in the world is not merely itself but involves every other object and in fact is everything else. In every particle of dust there is present Buddhas without number.'*
>
> —Sir Charles Eliot, as cited in F. Capra, *The Tao of Physics* (1999, p. 296)

terconnections between people that are often overlooked in everyday life. Although personal moral goals are significant, the importance of forming strong communities and identifying the moral goals of those communities must be appreciated for both individuals and communities to flourish.

An important point that distinguishes communitarian ethics from other ethical approaches, such as deontology or utilitarianism, is communitarians' acceptance that humans naturally favor the people with which they live and have frequent interactions. Deontologists, for example, base their ethics upon the existence of a more impartial stance toward the persons who are the receivers of their morally related actions.

Communitarians accept partiality as a way of relating to others but also believe that it is realistic to develop empathy and compassion toward people who are personally unknown to them. Nussbaum (2004) suggested that people often develop an "us versus them" mentality, especially when they are separated by significant cultural differences. People are able to generate sympathy when they hear about epidemics and disasters occurring on continents that are far away, but it is usually difficult for people to sustain that level of sympathy for more than a short period of time. People tend to stop and notice others' needs, but soon turn back to their own personal lives. According to Nussbaum, humanity will "achieve no lasting moral progress unless and until the daily unremarkable lives of people distant from us become real in the fabric of our own daily lives" (p. 958) and until people include others that they do not know personally within the important sphere of their lives. Nurses must broaden their scope of concern to include people affected by health care disparities, diseases, and epidemics all over the world.

> *A human being is a part of the whole, called by us the 'universe,' a part limited in time and space. He experiences himself, his thoughts and feelings, as something separated from the rest, a kind of optical delusion of his consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole of nature in its beauty.*
>
> —Albert Einstein

"All communities have some organizing vision about the meaning of life and how one ought to conduct a good life" (Wildes, 2000, p. 129). Community nurses have an important role in bringing populations and communities together to work toward a common humanitarian good. Transforming communities from a "them versus us" mentality to one that seeks a common good is possible through education (Nussbaum, 2004). "Children [and people] at all ages must learn to recognize people in other countries as their fellows, and to sympathize with their plights. Not just their dramatic plights, in a cyclone or war, but their daily plights" (p. 959). This need for empathetic understanding also is important within one's own country, state, town, and neighborhood. Many people are suffering within the United States because they lack adequate health care, food, environmental sanitation, and housing.

The education of communities often occurs through role modeling (Wildes, 2000). Members of communities learn about what is and is not accepted as moral through personal and group interactions and dialogue within their communities. Narratives are told about the lives of exemplars, such as Florence Nightingale in nursing, to illustrate moral living. In Nightingale's efforts to improve social justice and health protection through environmental measures and her efforts to elevate the good character of nurses, she exhibited moral concern for her local society, the nursing profession, and people remote from her local community, such as people affected by the Crimean War. In learning from Nightingale's example, communitarian-minded nurses are in an excellent position to educate the public and other health care professionals about why they in many ways should assume the role of being their "brother's and sister's keeper."

Beneficence

The principle of beneficence has to do with obligations to act in ways that would benefit or provide some good to others. Beauchamp and Childress (1994) focus on two aspects of beneficence: positive beneficence and utility. Positive beneficence provides the rationale for a number of specific moral rules generally accepted by our society (Box 11-4).

Theoretical arguments about beneficence have to do with the extent to which we are obligated to people who are not in a special relationship with us, the way in which chil-

dren, parents, and friends are. Are we obligated to everyone, or only to special people? Formalized relationships between health care providers and patients have been identified as special relationships that do obligate the provider.

Justice

Justice may be defined generally as "fair, equitable, and appropriate treatment in light of what is due or owed to persons" (Burkhardt & Nathaniel, 1998, p. 57). The major focus of ethical theories of justice in relation to health care is the concept of "right to health care," often meaning the right to government-subsidized health care for everyone. The arguments for or against the existence of such a right are consistent with the debaters' philosophical and political belief systems regarding the role of government in the lives of individuals.

In addition to being a major concept in the "principlest" approach to ethics, there are theories of distributive justice that "attempt to articulate, order, and justify principles that specify just distributions of benefits and burdens (other than punishments)" (Buchannan, 1992, p. 655). Buchannan identifies four major theories of justice: utilitarianism, Rawls' justice as fairness, rights-based egalitarianism, and Marxist egalitarianism.

> **"***Although we can distinguish between ethics and politics, they are inseparable. For we cannot understand ethics without thinking through our political commitments and responsibilities. And there is no understanding of politics that does not bring us back to ethics. Ethics and politics as disciplines concerned with praxis are aspects of a unified, practical philosophy.***"**
> —R. J. Bernstein. (1991). The new constellation: The ethical–political horizons of modernity–postmodernity. Cambridge, MA: MIT Press.

A Good Read

Ethics for the New Millennium (2001)
By Dalai Lama, New York: Penguin Putnam.

In a modern society characterized by insensitivity to violence, ambivalence to the suffering of others, and a high value placed on the profit motive, is talk of ethics anything more than a temporary salve for our collective conscience? The Dalai Lama thinks so. In his *Ethics for the New Millennium,* the exiled leader of the Tibetan people shows how the basic concerns of all people—happiness based in contentment, appeasement of suffering, forging meaningful relationships—can act as the foundation for a universal ethics.

BOX 11-4

Rules of Positive Beneficence
- Protect and defend the rights of others.
- Prevent harm from occurring to others.
- Help persons with disabilities.
- Rescue persons in danger.

Source: Bauchamp, T., & Childress, J. (1994). *Principles of Biomedical Ethics* (4th ed.). New York: Oxford University Press.

According to Donaldson (1992), the philosopher David Hume (1711–1776) is credited with first identifying the circumstances under which justice is necessary:

- *Dependence.* Individuals are not self-sufficient. They require the cooperation of nature and of other humans to "achieve certain critical goods."
- *Moderate scarcity.* Some scarcity is required because if there is an overabundance, justice is not required; if there is severe scarcity, a decent life is impossible to achieve.
- *Restrained benevolence.* Humans are generous, but only to a point. They may frequently sacrifice at all levels (family–country), but over the long term, they show a deep-seated resilience to self-interest.
- *Individual vulnerability.* No matter what one's status, anyone can be subject to attack from others.

Utilitarianism and its criticisms were discussed earlier in this chapter. Rawls' "justice as fairness" theory was developed partly as a response to the shortcomings of utilitarianism. Rawls (1999) asks that we imagine an ideal situation in which the principles of justice for a democratic and free society are developed from an "original position" by a group of representative people who are unbiased, in a situation of equality. This "original position" is one where the framers work from a "veil of ignorance," where they do not know who they may be or what position they may hold within the society. Rawls believes that the group members would want to maximize their own positions, whatever those may turn out to be and so, through deliberative rationality, would agree to accept his two principles of justice. Box 11-5 presents these principles.

The "just savings principle" refers to Rawls' belief that every generation has an obligation to "save" for future generations. Thus each generation should pass on to the next generation an amount of capital (e.g., factories, infrastructure, and other resources) and those institutions that would ensure their liberty and well-being; these assets include ideas and culture. Although it is expected that a given generation will pass on the opportunity for a better life, it is not expected that the generation will unduly deprive itself to do so. Each generation receives from the previous one and gives to the next. What seems to be a reasonable savings depends on the circumstances of each generation.

The general rules are those that would be worked out from the "original position" in which the group members, working behind the "veil of ignorance," do not know which will be their generation. Current generational issues include our Social Security system, natural resource usage, transportation infrastructure, and educational systems.

Critics of Rawls say that his theory demands too much from those who are better off, even when those who are worse off would not suffer or their conditions could not be improved. He is also accused of being too optimistic about the general acceptance of the ideal situation. If too many of the citizens are alienated from the culture, consensus may not be attainable.

Adherents to the philosophy of radical libertarianism take the position that the role of the state is to enforce property rights—not redistribute wealth, except to rectify past violations of individual property rights. Nozick (1974) responded to Rawls' theory by asserting that enforced redistribution of goods violates individual rights requiring interference with individuals' lives, causing unacceptable disruption. In addition, the redistribution is intuitively unjust. According to Buchannan (1992), Nozick's critics respond that current tax laws provide redistribution with only minimal disruption, and we cannot assume that injustice doesn't arise after an accumulation of individual transactions that, by themselves, appear to be fair.

The original Marxist theories proposed that the need for redistribution would disappear after a class leveling occurred and a common control of the means of production was implemented. Clearly, that has not happened in communist systems, and more moderate Marxists now believe that there will always be a need for a principle of enforced distributive justice. They focus now on Marx's vision of a more rational and humane, post-capitalist society.

BOX 11-5

Rawls' Principles of Justice

First Principle

Each person is to have an equal right to the most extensive total system of basic liberties possible in the society. These liberties can be restricted only for the sake of overall liberty. Liberty may be restricted in only two cases: (1) a less extensive than possible liberty must strengthen the total system of liberties for everyone and (2) a less than equal liberty must be accepted by those affected.

Second Principle

Social and economic inequalities are to be to the most benefit of the least advantaged, and offices and positions must be open to all under conditions of fairness of opportunity. Justice takes priority over efficiency and maximizing the sum of advantages. There are two exceptions: (1) any inequality of opportunity must be to the advantage of those with lesser opportunity and (2) an excessive rate of savings must generally decrease the burden of those who bear the hardship.

■ Justice in Health Care

Although Rawls' theory does not specify health care as a social good, Daniels (1985) believes that a theory of "just health care" was compatible as an extension of Rawls' general theory of justice and developed his theory based on assumptions of "rights to health care" in relation to individual needs. Daniels' composite list of rights is presented here:

- Society has the duty to its members to allocate an adequate share of its total resources to health-related needs, such as the protection of the environment and the provision of medical services.

Our Endangered Values: America's Moral Crisis (2006)

By Jimmy Carter, New York: Simon and Schuster.

President Jimmy Carter, Nobel Peace Prize Winner, is one of the most respected voices in the United States today in the areas of human rights, diplomacy, and good government.

In his book, *Our Endangered Values: America's Moral Crisis,* Carter presents a series of essays that outline his views about the key ethical and moral issues looming in the 21st century. Topics such as war, environmental negligence, the death penalty, civil liberties, moral responsibilities to the poor, and the separation of church and state are critically debated in the context of Carter's worldview and spiritual philosophy about our role as world citizens.

- Society has the duty to provide a just allocation of different types of health services, taking into account the competing claims of different types of health needs.
- Each person is entitled to a fair share of such services, where "fair share" includes an answer to the question, Who should pay for the services? (p. 8)

For Daniels, needs are defined as being "necessary to achieve or maintain species-typical functioning" (p. 26). If there is impairment of this functioning through either disease or disability, individuals are restricted in the expression of the normal range of opportunity their own talents and skills would otherwise allow them. Daniels proposed that the greater the impairment, the more important it is to prevent, cure, or compensate for the disease conditions.

In Daniels' theory, "normal range of opportunity" is defined for individuals as the reasonable life plans available to them in their particular society if they were healthy. This definition implies that there will still be differences among individuals (e.g., normal genetic endowment and cultural expectations and limitations). The emphasis is on fairness, meaning that society must refrain from imposing barriers to equal opportunity and must correct for interferences to equal opportunity. The assumption of the Rawlsian "veil of ignorance" should be applied here in regard to decisions about needs.

Allocation of societal resources among all social needs and among the various levels of health care needs (prevention, cure, restoration, and extended support) requires both moral judgment and extensive empirical knowledge about allocation consequences. Daniels also points out that protection of opportunity must not undermine a society's productive capacity.

In his analysis, Daniels deals with two related issues in the application of his theory: equitable access to health care and paternalism. Three general approaches may be taken in dealing with the issue of access. The first is utilization rates, by which differences and similarities in usage among groups are identified. For example, if a service is utilized equally between upper- and lower-class subgroups, equality of access is thought to exist. The second is the process approach, in which process variables are examined to determine whether some variable, such as geographic distance or waiting time, makes the process more burdensome for some. The third approach, the market approach, determines that access is equitable if there are no information, supply, or financial barriers that prevent access to what is referred to as a "reasonable" or "decent basic minimum" of service. Daniels asserts that the "decent minimum" in health care should reflect our ideas of "tolerable life prospects."

Daniels also proposed a "theory of justifiable paternalism," which relates to issues of equitable risk prevention in the prevention of disease. Reduction of disease risk may include general measures, such as mandatory water and waste treatment from which everyone benefits equally; alternatively, it may be specific, targeting workplace risks where only some individuals are affected. Regulating workplace risk by imposing standards and rules is said by some to be in conflict with an individual's freedom in lifestyle choices and the right to take risks voluntarily.

What needs to be considered is whether the workers (1) are truly informed of all risks to health, (2) are truly able to make a choice without depriving themselves of a reasonable living, and (3) are not subject to overt or covert coercion. Daniels states:

> In general we ought to preserve autonomy. . . . But we are not bound to preserve the illusion of autonomy. If unregulated worker "choices" about risk-taking must fail, or generally do fail, to be informed, competent, or truly voluntary, then we are not compromising autonomy by intervening. (p. 159)

Values and Health Policy

As Schlesinger (2002) explains, historically a market-based model for health care has had a variable level of support in the United States. Support has markedly increased since the beginning of the Reagan administration in the early 1990s. The market-based model views health care as a

commodity similar to material goods, subject to the laws of supply and demand in relation to availability and cost. It has competed with two alternative models: the medical professionalism model and the societal rights model.

The medical professionalism model rejects the idea that consumers are competent to make good medical choices, arguing that medical care is too complex and still under development. Proponents of this model believe that medical providers should make health care decisions. The Great Depression of the 1930s saw the emergence of the "societal rights" framework. In the early 1940s, President Franklin Roosevelt called for the rights for all to medical care and the opportunity to achieve and enjoy good health.

The role of the government within the medical professional model is to promote scientific knowledge and the training of professionals. By contrast, in the social rights model, the role of government is to ensure a standard of equality and equal access to services. The then-dominant "rights" model during the 1960s and 1970s saw increases in the role of the government with the establishment and expansion of programs such as Medicare, Medicaid, and other health and social programs. The swing toward the market model was driven primarily by the marked increases in the costs of these health care programs. In the market model, the role of government is to support fair competition among providers.

Political conservatives have been among the entities most interested in cost reduction and in reduction of the role of government in health services. However, liberals were also supportive of "managed competition," believing it would transform medical care by breaking up the entrenched interests of the medical profession and make it more responsive to consumers—hence the support from the Clinton administration for expansion of managed care.

☞ THINK ABOUT THIS

Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person: the neighborhood he lives in; the school or college he attends; the factory, farm, or office where he works. Such are the places where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world.
—Eleanor Roosevelt (1884–1962),
U.S. author, diplomat, and First Lady,
statements at presentation of "In Your Hands: A Guide for Community Action for the Tenth Anniversary of the Universal Declaration of Human Rights," March 27, 1958

How has the United States changed since 1958 in regard to justice, as related to health care?

In spite of the support from both conservatives and liberals, there has been little real progress toward health care reform. Many proposals have been attempted, but until recently, at least, the reform has been limited. In an effort to understand these failures, Schlesinger (2002) carried out a series of research studies examining the values held by liberals and conservatives of both the "Washington elite" (congressional staff who had designated responsibility for health issues) and the general public. Table 11-1 shows the percentage of the "elites" identified as advocates for the market model who agreed with statements related to allocation of responsibility for care and health care issues. It can be

Table 11-1   Percentage of Positive Responses of Policy Elites Who Advocate the Market Health Care Model by Self-Identified Political Ideology

Fairness Measure	Conservative	Liberal
■ Individuals should be responsible for their own		
Physician and hospital services	87.0%	4.2%
Nursing home and home health care services	69.1%	0.0%
Substance abuse treatment	83.3%	6.7%
■ Norms for Health Care Equity		
Most fair if individuals decide for themselves about health insurance and health care that matches how much they want to pay for it	100%	100%
The most productive people should make the most income and be offered the best fringe benefits	40%	11.1%
Equal treatment is the most important aspect of a just health care system	0.0%	55.6%
Health care should be based on needs, as determined by a medical expert, regardless of cost	20%	66.7%

Elites who identified themselves as moderates are not included in this table.

Source: Adapted from Schlesinger (2002, p. 904).

Table 11-2   Percentage of Agreement with Ethical Norms Items Among Elites and the Public by Market Advocacy

Ethical Norm Measure	Elites		Public	
	Advocate	Non-advocate	Advocate	Non-advocate
■ Most fair if individuals could decide for themselves about health insurance and health care that matches how much they want to pay for it	85.7%	20.6%	79.4%	46.4%
■ Most productive people should make the most income and get the most fringe benefits	23.8%	12.9%	31.8%	27.8%
■ Equal treatment is the most important aspect of a just health care system	42.9%	64.7%	82.5%	67.9%
■ Health care should be based on needs as determined by medical experts, regardless of cost	38.1%	44.1%	76.2%	73.2%

Source: Adapted from Schlesinger (2002, p. 907).

clearly seen from the data that although all respondents were supportive of a market model, they held very different views about issues of responsibility and equity in health care.

Schlesinger found that while 58% of congressional health staff supported the market model for health care reform, only 41% of the general public did so. When he compared the congressional staff with the general public on the responsibility measures, he found that market advocates among the elite were almost twice as likely as non-advocates to agree that individuals should be responsible for their own health care. By comparison, market advocates of the public were slightly less likely than non-advocates to support the personal responsibility statements. The differences between the groups were even more pronounced when Schlesinger considered the norms of fairness items; these responses are shown in Table 11-2. He concluded that these differences between the general public and the congressional elite may account for the problems that have emerged in trying to implement a market approach to health care reform.

❝*In the end, we will remember not the words of our enemies but the silence of our friends.*❞

—*Martin Luther King, Jr.*

Ethics of Care

The previously discussed theories have in common the use of moral principles to guide behavior. These theories are concerned with the rights of individuals within a society and the obligations of individuals to others and to society. A more recently developed theory, known as the **ethic of caring,** takes a different position—namely, that relationships and responsibilities are more important than rights and obligations or outcomes. In this approach, the primary focus is on the well-being of the whole person. This means that the nurse

❝*When nurses are attentive, efficient, and effective in their practice, they are being morally good persons, because they are fulfilling the moral sense of nursing by fostering the well-being of patients.*❞

—*A. Bishop & J. Scudder. (1990). The practical, moral, and personal sense of nursing: A phenomenological philosophy of practice. Albany, NY: State University of New York, p. 112.*

is concerned with all aspects of the patient's well-being, not merely the disease process. Care is designed for needs in all realms—physical, psychological, social, and spiritual—with the understanding that each affects the others and the totality of health. The broader social environment that affects the patient is also of concern, such as the family. Nursing actions are deemed ethical when they take into consideration this whole person, who is labeled the "patient" or "patient." They are unethical when they focus on the disease process or disability.

There is also a component of compassion, which is a precursor to caring. The nurse who practices from this care approach will be concerned with developing personal characteristics and taking actions that will show caring. This ethical approach is still developing within nursing, where care has always been central. There are many barriers within the present health care system that interfere with care for the whole person, such as a technology focus, managed care, and specialization (Purtillo, 1999).

The ethic of care rings true for many nurses who believe it describes the context of and their feelings about their work. It is the connectedness and responsibility for having met the needs of individuals under their care that give satisfaction. Benner (1984) provides many examples from her interviews that support this view.

The person living a caring ethic bases his or her actions on the needs of those for whom the individual cares, either

BOX 11-6

The Ethics of Care
- The focus is on the whole individual.
- The caregiver has a responsibility to meet the needs of those for whom the person is caring.
- There is an affective element of compassion in the relationship.

naturally or in a formal caring relationship. For the community health nurse, the focus changes from the individual to the population, but responding to needs at all levels remains the same (see Box 11-6).

Ethical Problems Faced by Community Health Nurses: The Research

Several studies identifying the ethical problems related to community health nursing have been conducted by nurse researchers in both the United States and other countries. In one study, Aroskar (1989) sent questionnaires to more than 1,000 staff nurses who worked in community health and public health agencies in Minnesota. More than 300 nurses responded, listing the problems they had encountered. Aroskar categorized the problems according to the type of ethical conflict they represented. These categories and some examples are shown in Box 11-7.

BOX 11-7

Community Health Nursing Problems Categorized by Ethical Conflict

Conflict Between Autonomy and Beneficence
- Getting patients to be responsible for their own care and well-being
- Wishes and rights of patients about living, dying, and refusing treatment
- Unnecessary treatment (use of narcotics)
- Apparent negligence of a child without evidence to report
- Refusal of treatment when the patient's condition is deteriorating

Conflict Between Truth-Telling and Nonmaleficence
- Stretching the truth or game-playing to satisfy criteria for treatment
- Withholding information or lying to the patient about diagnosis or treatment
- Nonbetrayal of colleagues to the patient and/or family about quality of care

Distributive Justice
- Unnecessary government subsidization for low-income families
- Lack of funds for medical care
- Struggle for equal care, regardless of race or finances

Source: Aroskar (1989).

BOX 11-8

Types of Ethical Conflict Reported by 40 Louisiana Public Health Nurses

Type	Frequency	Percentage
Confidentiality	21	53
Privacy	16	40
Whistle blowing	16	40
Informed consent	13	32
Conflict of interest	13	32
Other discrimination	9	23
Truth-telling	7	18
Discrimination against patient	6	15
Disclosure	2	5

Source: Folmar, Coughlin, Bessinger, & Sackoff (1997).

In a survey of 40 public health nurses in southern Louisiana, Folmar, Coughlin, Bessinger, and Sackoff (1997) found similar results to those uncovered by Aroskar. Those findings are shown in Box 11-8 in order of frequency of report.

In another study, using a list of 39 ethical problems, 745 hospital and community nurses were asked to indicate each one they had encountered in the last 12 months. The researchers (Wagner & Ronen, 1996) reported the 10 most frequently encountered dilemmas. Again, the major issues were similar to those found in previous studies. The percentages of nurses experiencing the most frequently encountered dilemmas are reported in Box 11-9 for the 239 community health nurses in the study. The community health nurses reported similar issues as the hospital nurses, but generally encountered them less frequently.

BOX 11-9

Issues Most Frequently Encountered by Israeli Community Health Nurses

Dilemma	Percentage
Need to care for offensive patient	85
Conflict between patient and family needs	69
Inability to treat—staff shortages	61.2
Reporting incompetence of nurses or physicians	57.3
Rude or offensive behavior toward patient by nurse	48.9
Giving treatment perceived as a mistake or wrong	52
Violence by patient or family toward caregiver	48.7
Withholding information from patient—family wishes	45.2
Giving treatment of questionable value	49.8
Pressuring a patient who refuses treatment	48.2

Source: Wagner & Ronen (1996).

Gremmen (1999), using a grounded study method, interviewed 33 Dutch visiting (district) nurses, asking them about that they considered to be central to their work. This researcher was interested in the nurses' moral reasoning about their work. The theoretical focus of her study was on the apparent conflict between an ethic of care and an ethic of justice. The nurses described how they handled situations in which patients were resistant to treatment. Analysis of the interview data showed three parts to the process the nurses described, which Gremmen labeled "tuning in to the patients' lives," "convincing or even pushing patients while not forcing them," and "not withdrawing from patients while disagreeing with them." It was her conclusion that care and justice are both crucial to the work of public health nurses and can be complementary.

As part of a study of 30 community health nurses in British Columbia, Canada, Duncan (1992) asked them to report the clinical situations that created ethical dilemmas. One condition involved "patients' rights," specifically related to high-risk families, adults with mental health concerns, and adolescents who were at risk but didn't want their families involved. A second condition was described as "system interaction"—that is, problematic situations between nurses and consumers and problems with inadequate resources. "Allocation of resources" included problems about limiting resources for resistant patients, allocating visits, and effectiveness. "Nurses' rights" was the final condition. Employment contracts, high case loads, and limited resources jeopardized the nurses' rights to act according to their own values.

🔨 ETHICAL CONNECTION

It is not unusual that moral uncertainty is first experienced and escalates to moral distress as patients' rights are not respected or as institutional constraints are applied and nurses feel unable to act on their moral choices and judgments.
—A. Hamrick. (2000). Moral distress in everyday ethics. *Nursing Outlook, 48,* 199.

Oberle and Tenova (2000) asked 22 Canadian public health nurses the following question: "Please describe a frequently recurring ethical problem (or problems) that you have experienced in practice—something that has been a common problem for you." Follow-up questions related to support and how they resolved the problems. The researchers identified five themes based on their analysis of the transcribed interviews:

Theme 1: Relationships with health care professionals. Relationships were ethical problems when they prevented the nurse from delivering optimal care—for example, the physician denigrating the nurses' advice, one-way communication only, and observing inferior care.

Theme 2: Systems issues. Systems issues included resource distribution, such as performance of quality care with in-adequate resources; choices about offering programs, including how much and to whom; and too few resources.

Theme 3: Patient relationships. This theme encompassed issues such as the context and nature of the relationships, empowerment versus dependency, and boundary setting. The fact that the patient controlled the continued existence of the relationship challenged the nurses to find ways to establish working and trusting relationships. They had to decide between not intervening in some events to maintain the relationship and taking action to stop risky behavior (e.g., poor parenting). Professional versus personal relationship issues were more problematic in rural settings, when patients were encountered in social settings.

Theme 4: Respect for persons. Respecting autonomy was interlaced with all the themes and was seen as foundational to public health nursing. The issues in regard to autonomy were the questioning of whose rights (among family members) should be supported, deciding when someone was unable to make their own decisions, and learning how to be a confidante and still maintain confidentiality when the information was something that would be helpful to other providers.

Theme 5: Putting self at risk. Situations involving risks to the nurse's personal integrity and physical danger were the issues in this theme.

Ethical Decision Making

Dozens of institutes and centers focus on the study of bioethics, most of these associated with universities. Some universities offer degree programs in ethics and in clinical ethics. More and more often, health care agencies use qualified ethicists on ethics committees as consultants to help them with ethical problems. In larger agencies, nurses are able to consult ethicists to help them with ethical decision making.

Often, however, nurses themselves must reason through the ethical problems they encounter. Several authors have presented decision-making models, most of which are based on a problem-solving format. The common steps in the process include these:

1. Determine how these problems affect the autonomy and quality of life of the individual. For example, is the person mentally competent? Is the health problem life-threatening? Is the individual able to communicate and relate to others? To what extent can the individual care for himself or herself? Is the problem likely to get worse? What kinds of treatments are available, proposed, and usual? Are the treatments likely to have positive outcomes? How painful or intrusive are they? What information does the person have about the problem?

2. Separate the ethical issues from those of a strictly medical nature and determine which individuals and groups will be affected by the decision. For example, what is

important for the patient? Which principles are involved: respecting the person, preventing harm, doing good, providing justice, maximizing outcomes for the greater number? Who are the stakeholders in this situation: family, hospital or agency administration, physicians, nurses, the community?

3. Identify and understand the values of those who will be affected, including those of the nurse. What do the individuals involved think about relevant issues, such as quality of life, prolonging life at all costs, autonomy in the face of increased risks, suffering, and the responsibilities of caring?

4. Develop alternative options and weigh them in the light of the rights and obligations of all concerned. What harms and benefits accrue to each of the stakeholders in relation to each option? If a patient refuses chemotherapy, for example, does this decision conflict with the physician's belief that such treatment will be beneficial? Will a family member feel guilty because "everything possible" wasn't done? Are there financial savings for third-party payers?

5. Decide on a course of action and later evaluate the outcome. Part of the decision includes determining who should make the decision.

This framework was designed primarily for use in situations involving individual or family care. Kass (2001) has developed a six-step framework for public health and aggregate populations that poses questions to be asked of program developers.

1. *What are the public health goals of the proposed program?* The goals should be related to reduction of morbidity or mortality. The goal may be an intermediary one, but there should be awareness of the relationship to the ultimate goal.

2. *How effective is the program in achieving its stated goals?* This step requires that assumptions about the effects of the program be identified and documented to the extent possible from previous research or program results.

3. *What are the known or potential burdens of the program?* There are usually three major burdens associated with public health programs: risks to privacy and confidentiality, risks to liberty, and risks to justice. Disease surveillance and vital statistics, communicable disease reporting, and contact tracing all have the risk of loss of confidentiality. The burdens of these programs are borne by the target groups for the benefit of all others, and there is a risk of biased reporting. Health education programs include the possibility that they may not work, may involve manipulation or coercion, and are potentially paternalistic. If findings from research studies are never implemented, there is potential harm to participants who have been misled about the goals of the project. Regulation and legislation constrain freedom of choice and often target some groups for the benefit of others (immunization, motorcycle helmets, smoking).

4. *Can burdens be minimized? Are there alternative approaches?* Programs must be modified to impose the least burden possible without decreasing effectiveness.

5. *Is the program implemented fairly?* Burdens and benefits must be distributed fairly and not solely to specific targeted populations without adequate justification.

6. *How can the benefits and burdens of a program be fairly balanced?* Health officials and professionals have a responsibility to promote programs that increase health benefits and to prevent programs that are unethical. Minority opinions must be taken into account; although dissent is not a reason not to implement a program. The greater the burden imposed by a program, the greater must be its benefits.

One time-honored approach to ethical decision making entails comparing the present case to those in the past. This process, known as **casuistry**, starts with identifying the relevant points and finding how this case is the same or different and which principles then apply. This approach has been foundational for developing church and judicial precedents.

Service Learning: Discovering the Self and Developing Community Values*

One skill needed for developing ethical responses is what is called a *moral imagination*. In Kohlberg's terms, the imagination develops with moral growth. This imagination gives one the ability to see the moral dimensions of more situations and to empathize with more issues, sides, and sentiments. Such an active imagination is developed with experience and contact with events, situations, and others' ideas. What are your beliefs about the importance and effects of your own personal decisions and actions in the world of nursing and society? How might you find out? What are your values, positions, and beliefs about those people beyond your familiar community? How have you learned those values? Might they change? Do you really know your community? Who do you want to include or exclude from your personal community and why? What are the experiences of people who are different from you? The more these questions are asked and reflected on, the greater the moral imagination.

Even though learning by experience has always been a part of nursing through clinicals, practicums, and laboratory assignments, a new interest has grown in a different form of experiential learning called **service learning**. Service learning emphasizes needs and benefits to an actual group of persons or community rather than solely focusing on student academic and career learning. It is also distinguished by having an overt goal of developing a social consciousness, values, and skills regarding civic responsibility. In addition, to truly be service learning, it must include a strong emphasis on personal insight with planned methods and scheduled time for self-reflection and self-discovery.

*This section was written by Dr. Sherry Hartman, Associate Professor Emeritus, University of Southern Mississippi, School of Nursing.

The focus with this approach is on the lessons learned and insights gained from performing service work, not just clinical or professional intervention. The learner in performing a service is a "servant" to others. Many in nursing believe that service learning can help nursing develop and strengthen the legacy of values believed to underlie both nursing and public health. Service learning lets students face situations in which they foster intangible qualities and values such as empathy, self-awareness, self-confidence, a caring activism to advocate for health, a sense of democratic civic responsibility, a global ecological awareness, cultural competence, and social justice. These are learned in such a way as to become part of a student's life experiences; in turn, these experiences develop the moral imagination.

Even if your university does not have a service learning program, you can apply some of the methods yourself. When working in community centers, such as daycare centers, Meals on Wheels, senior centers, youth services, soup kitchens, drug education programs, and so on, think beyond the patients' immediate health concerns. Think also about what it feels like to see yourself "serving" them. Is "serving" a positive image for nurses? How can a group or community best be "served"? What is in their best interest? What gets in the way of meeting their needs? How can members of the group be empowered to help themselves? Which organizational, local, state, or federal policies need to be changed to assist them? How do you feel about the needy? What did you or anyone else do to contribute to their situation? What are your beliefs about them and their situations? Are justice and care present in their lives? How much are you influenced by the beliefs of your friends, family, church, and the dominant society? Do you have any obligations to the members of the group, beyond their physical health concerns? Would your personal beliefs and values ever make a difference?

Conclusion

Because of the special relationship nurses have as care providers to their patients, they are frequent participants in ethical decision making relating to patients, families, and the community. Expectations of the community and the profession require that nurses possess certain virtues that will promote trust in all their professional relationships. Ethical decision making is based on the particular values individuals have acquired both as children and as thinking adults.

This chapter has presented the major thinking of philosophers, theologians, and other ethicists over the centuries. It should be clear that there is disagreement on both generalities and specifics. It is characteristic of the United States that there is wide variation in cultural, religious, educational, and ethnic backgrounds, and it is inevitable that values will also differ. We do, however, have many values in common. More recent philosophical approaches (post-modernism) present the view that there are no certainties and no foundational beliefs: We must each make our own way.

The value of understanding the principles of ethical theories is that it provides us with starting points for thinking through and developing our own set of beliefs, and our own frame of reference for the practice of nursing. For whether we like it or not, we are involved in situations that demand an ethical response almost daily in our work.

Explore Community Health Nursing on the Web! To learn more about the topics in this chapter, use the passcode provided to access your exclusive website: **http://nursing.jbpub.com/ communityhealth.** If you do not have a passcode, you can obtain one at this site.

Application to Practice

The Need for Home Care

Lila S., age 68, was referred to a home health agency after her discharge from an acute care agency, where she had been hospitalized for pneumonia and stabilization of her diabetes with insulin regulation. She lived with her six-year-old granddaughter in a small, grimy, cluttered trailer. The whereabouts of the girl's father were unknown, and her mother was in and out of drug treatment units.

Lila's poor eyesight from cataracts made it difficult for her to test her blood glucose or measure her insulin. Painful leg ulcers and arthritis made it difficult for her to walk.

Medicaid allowed four home visits by the nurse. This nurse had made home visits to Lila in the past and saw that her ability to care for herself had decreased and that she would need more help in the future. Lila S. has always been quite independent and does not agree that she is not taking care of herself well. She believes it is important that she maintain a home for her granddaughter.

Medical Issues

- It is important that Lila S.'s glucose be monitored and that her insulin dosage be adjusted accordingly. Her diabetes is fairly stable but needs careful monitoring because of the severe episode of hyperglycemia that accompanied the pneumonia.
- Lila S.'s poor eyesight increases the probability that she will make errors in her diabetes regimen.
- The leg ulcers require care and should be monitored by a knowledgeable person.
- Lila S.'s diminished mobility increases her ability to go to sources of help.

Based on her assessment, the nurse decides that Lila S. needs a nurse to visit several times a week to monitor the glucose readings and help her adjust dosage and inject her insulin. Ideally, these visits should be done every day. An appeal made to the Medicaid reviewer for additional visits was denied, and the home health agency closed the case.

Ethical Issues

The nurse understood that the agency must have reimbursement for the services it provides; however, she believed that she and the agency had an obligation to continue care that they had begun for this patient, who was obviously in need and whose lack of care might be life-threatening. Legally, no such obligation exists. Various possibilities were discussed with the patient, including trying to find someone she could live with or who could live with her, or going to a nursing home. Lila S. was insistent that she remain at home and care for her granddaughter. The ethical issues involved in this situation are as follows:

- The right of the patient to decide how she wants to live (autonomy)
- The responsibility of the nurse to do no harm or to prevent harm by not abandoning the patient (nonmaleficence) or causing harm to the granddaughter
- The responsibility of the nurse to provide competent care, directly or indirectly, to the patient (beneficence)
- The justice of a health care system that will not pay for needed health care that would be less expensive and likely prevent the otherwise high probability that the patient will need more expensive care later

Utilitarian Approach

Utilitarians would start with the question, "Who would be affected by decisions in this instance?" The person most affected is the patient herself; next most affected is her granddaughter. The nurse and the home health agency also have some stake. Finally, society in general may be affected. In determining what would accomplish the most good for the most people, the effect of the decision on society would have the highest priority. Continuing home care to this patient might be expensive at the time, but the long-range projection is that without the immediate care, the patient will probably need much more expensive treatment and additional hospitalizations later. Based on concrete information about costs, utilitarians would most likely decide in favor of continuing visits. They may also attempt to change the laws or regulations that tend to prohibit the more cost-effective solution.

Deontological Approach

The deontological, rule-based approach would examine the rights and obligations of the participants and determine which had higher priority. The foremost right is the right of the patient to make her own decisions based on her own values. The providers are obligated to determine whether the patient is competent to make rational decisions.

There is no reason to believe that Lila S. is incompetent, except for her unawareness that she is less able to care for herself. She values her independence and should be allowed to remain in her home. The providers are then obligated to allow and, preferably, support that choice by providing services to help her remain at home.

Another right of the individual is that of not being harmed by others. The health care providers must examine the medical and social information to determine whether the actions they take will be harmful in any way. Given the current situation, two alternatives present themselves. First, Lila S. remains in her home. It is probable that her diabetes will again go out of control. She will need hospitalization and may possibly need amputations. In this instance, she

Application to Practice—cont'd

remains autonomous but incurs harm in the progression of her health problems. A second alternative is that Lila S. is persuaded to enter a nursing home, where she can get daily help with her medical and physical needs. The harm in this scenario is that her sense of self as an independent person may be damaged, and she may feel guilty for not taking care of her granddaughter. Whether the deontologist values autonomy or nonmaleficence most, the preferred solution for Lila S. would be continuing home visits.

Additional harm may be incurred by separating the granddaughter from her grandmother, who has provided a stable home and, presumably, love. If the granddaughter were older, she might be enlisted to help with the insulin injections, and perhaps the grandmother will not suffer any serious problems until the granddaughter is of an age to help.

The justice consideration is readily evident in this case: What would seem to be a decent minimum of care cannot be provided because the woman is poor. It is not clear that Lila S. was born disadvantaged, except that diabetes has a large genetic component. Being poor does mean you may not get the early health care you need and may suffer more negative consequences than others.

Caring Approach

The major focus of the caring approach to this ethics problem will be the responsibilities of the nurse to the patient with whom she has a formal caring relationship. The legal contract for the relationship stipulates a certain number of visits, but the emotional contract has a broader scope. The patient will expect that the nurse will do everything possible to help her achieve her health goals. These expectations may include not abandoning the patient while she still needs help.

The nurse will respond to these expectations and try various avenues to enlist the help Lila S. needs to remain at home. If all else fails and the agency cannot continue visits; the Medicaid administration will not change the ruling; and no relatives, friends, or neighbors can be found to help; there is one last solution. The nurse may decide to utilize personal time, such as lunch hours to provide the needed nursing care. This kind of devotion is above and beyond what is expected legally or ethically, but the feeling of responsibility for some patients may generate that kind of behavior.

In all of the approaches described for this case, the issue of financial support is important. If finances were not a barrier, Lila would get all the help she needed to maintain herself and her granddaughter at home and satisfactorily manage her health needs. It is impossible to consider health care for individuals or groups without considering the benefits and cost to society. Even though a person may take a deontological or a caring approach to ethical decision making, most of the time the ultimate financial outcome must be considered. 🔶

■ CRITICAL THINKING ACTIVITIES

1. Some nursing students cheat on examinations. This implies an absence of virtue, and many believe that those individuals cannot then be trusted to be honest about the care they give to patients, because they may endanger patients by lying to protect themselves about errors or omissions of treatment. Should dishonest students be denied a license to practice nursing? What is the responsibility of other students who know about the cheating?

2. As a patient or as a family member of a patient, what virtues would you expect of a nurse? Is it reasonable to expect these virtues?

3. A 14-year-old girl revealed to the school nurse that she was sexually active and wanted contraceptive medications. She had seen many of her peers become pregnant, and she stated that she was not ready for a child, but planned to continue her sexual activity. What are the ethical considerations for the nurse in this situation?

4. John, age 32, is known to the public health clinic staff from his visits for intramuscular Haldol injections. He has spent time in the state hospital, where he was diagnosed with paranoid schizophrenia. John was stabilized on medication and discharged to live with his sister, who is married and has four children. He stayed with her only two weeks; he now lives under a bridge. He eats irregularly and has poor hygiene. The original plan was for John to be seen at the mental health clinic, but he refuses to go there. Most of the time his sister is able to persuade him to obtain his medication at the public health clinic. Recently, his sister reported that John is thin and appears ill. He refuses to return to her home and, when pressed, becomes angry and shouts that he wants to be left alone. The sister has appealed to the clinic staff to do something. What are the ethical considerations in this situation?

5. Select a local public health program you know about, or develop one you believe your community needs. Show how this program does or does not meet the ethical criteria proposed by Kass (2001).

6. In a large general hospital, many nurses and auxiliary personnel complain to the clinic staff about chronic back pain related to their jobs. The hospital administration has not been responsive to their complaints. Is this an instance in which regulation of ergonomic devices by OSHA should be required, or would this be unnecessary paternalism?

7. Develop a health care plan for your state that follows Daniels' justice theory. Start by identifying your values and goals.

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