AN ABSTRACT OF THE THESIS OF

Tina T. Dinh for the degree of Honors Baccalaureate of Science in Human Development and Family Sciences presented on May 24th, 2012. Title: Nursing Ethics Across the Lifespan: The Past and Present Role of the Nurse in Relation to Patients and Physicians.

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Nurses are known to have "big hearts," but in order to fully understand their own thoughts and actions in practice, nurses need to develop their minds. Nursing ethics deserves recognition because all nurses need an understanding of ethical concepts in order to recognize ethical issues and dilemmas. The ideal ways of acting in nursing should be universal so that care for patients is consistently exemplary. Nurses need to learn to support their beliefs and ideas with sound reasoning to understand, relieve, or prevent their own moral distress.

This paper briefly examines the history of nursing and nursing ethics, the dynamics of the nurse-physician relationship historically and in the modern era, the shift of the nurse from a helper into an autonomous professional within the healthcare system, and exploration of the role of the nurse as an "advocate." The ethical theories and approaches used were virtue ethics, deontological ethics, utilitarian ethics, the principlism approach, and the ethic of care approach. Case studies were then used to highlight the nurse-patient relationship, the nurse-physician relationship, and the lessons that could be drawn for to help the nurse in practice.

Key Words: Nursing, ethical theory, advocacy, moral distress, professional codes

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Nursing Ethics Across the Lifespan:

The Past and Present Role of the Nurse in Relation to Patients and Physicians

by

Tina T. Dinh

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I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

Tina T. Dinh, Author

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INTRODUCTION

Personal Statement

While the simplicity of childhood is what the adult longs for, it seems the child aspires to grow up and live life as an adult. This can be evidenced by the type of toys children find appealing: ones that mimic adult occupations. When I was a child, I had a white lab coat and a toy stethoscope. They were gifts from my mother who harbored a lifelong dream of her children becoming physicians. The toys, and my mother's constant influence, convinced me to pursue medicine. From age four through my first year of college, I was adamantly focused on becoming a physician. I knew my passion was science and that I had the gift of an extroverted personality so I didn't question the decision, but soon after I found the role of a physician, although highly respectable and altruistic, an improper fit for me.

Becoming a physician had been such an integral part of my life that I felt lost for some time after my decision. I began doing research on other careers within the healthcare field and found a few appealing options, but I did not make a conscious career decision until I spent time shadowing a nurse practitioner. She practiced in a clinic so she was very familiar with her patients. I watched her lovingly interact with her patients and provide care specific to their lifestyles and need. She knew her patients and had developed real relationships with them. My time with her inspired me to pursue nursing,

which incorporates my passions of the biological sciences, relationships, and service to others.

According to the American Nurses Association, nursing is "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA). I found the concepts of nursing to be natural extensions of my personal goals and values.

I want to live out my faith in a tangible manner and I want to serve others and create meaningful relationships. In the New International Version of the Bible, 1 Peter 4:10 states, "Each of you should use whatever gift you have received to serve others, as faithful stewards of God's grace in its various forms." I am fascinated by biology and the intricacies of the human body and I believe this is a desire I have been given. I want to use my interests and my love of conversing to serve others. I want to create relationships with patients, even if short lived, to let them know that I genuinely care about them and their health. Galatians 5:14 says "For the entire law is fulfilled in keeping this one command: 'Love your neighbor as yourself.'" These values can be incorporated into my professional career by serving the physiological needs of ill persons in society. Going to a healthcare facility for an ailment or affliction can be an overwhelming experience. My goal is to help ease patient anxiety and attend to the body using my nursing skills and knowledge while treating people in a caring manner.

Compassion, justice, and a virtuous character are important in my personal morals and ethics. I aspire to have a professional career that emulates my personal values and I long for an educational foundation in my professional ethical behavior. Nursing ethics is

an important subject to me because it provides commentary and analysis about the type of person I want, and ought, to be in the professional healthcare realm.

The Importance of Nursing Ethics

The field of nursing was pioneered in the mid 1800's through the work of Florence Nightingale, but the profession of nursing has changed dramatically since Nightingale's time. Nursing ethics have also developed alongside the profession, but the foundation of modern nursing ethics was built upon the Judeo-Christian beliefs of moral virtue, duty, and service to others. Along with technical skills and abilities, a nurse must exhibit a compassionate demeanor and strong moral framework. Nurses are known to have "big hearts," but in order to fully understand their own thoughts and actions in practice, nurses need to develop their minds. The subject of nursing ethics deserves recognition because all nurses need a basic understanding of ethical concepts in order to recognize ethical issues and dilemmas that will inevitably occur in the workplace. The ideal nurse and the ideal ways of acting in nursing should be universal and discovered through nursing ethics so that care for individual patients, families, or communities is consistent and exemplary. Nursing ethics relate specifically to the ethical issues that affect nurses and their patients in nurses' daily work, regardless of what that may be. Nurses need to learn to support their beliefs and ideas with sound reasoning to understand, relieve, or prevent their own moral distress.

Thesis Statement

What ethical theories and perspectives can be used to help solve or understand ethical situations in nursing? How do the past and current nurse-patient and nurse-physician relationships affect ethical dilemmas?

This paper will briefly explain and examine the history of nursing and nursing ethics, the dynamics of the nurse-physician relationship historically and in the modern era, the shift of the nurse from a helper into an autonomous professional within the healthcare system, and exploration of the role of the nurse as an "advocate." Ethical theories and approaches will be explained (on a very basic level) and case studies will be used to analyze the ethical theories.

CHAPTER I

Historical Background of the Nursing Role and Nursing Ethics

In order to fully understand nursing ethics, the history of nursing as a profession must first be understood. The role of nursing was seen as the extension of womanly duties in domestic roles, so the majority of the nurses were women. Florence Nightingale (1820-1910), a pioneer in the field, came to nursing through a religious calling and was committed to high moral character and service to others because of her spiritual beliefs. This representation was prevalent throughout the mid 1800's and early 1900's and was conveyed in early textbooks on nursing ethics. Isabel Hampton Robb (1860-1910), the first president of the ANA and the author of the earliest book on nursing ethics, considered the nurses role as ministry and to be "a consecrated service, performed in the Spirit of Christ" (Robb, 38). During the first half of the 20th century, the nurse was viewed as an obedient and good Christian woman in service to others. The religious inspiration with which nursing began may not be as common for today's nurses, but it has still contributed to the framework of modern nursing ethics. Moral virtue, duty, and service still serve as the foundation of professional nursing ethics. It is important to note that etiquette was taught in conjunction with ethics. For many nurses, the two were indistinguishable. Ethics was taught to promote a good moral character, while nursing etiquette, which includes courtesy, neatness, punctuality, and a mild demeanor, was required to help the professional realm run fluidly (Fry, 1901).

The Historical Nurse-Physician Relationship

The harmony of the professional realm was an important aspect in nursing ethics during the early 20th century. The nurse, in most cases, was a quiet mannered and obedient woman who took orders without second guessing authority- in this case, the male physician. The nurse's duty was to help the physician, and ultimately the patient, although the patient was not always the nurse's first priority. The etiquette and ethics books taught nurses to obey the physician's orders, regardless of differing opinions. "His [the physician] wishes are to be law to the nurse. The question whether she agrees perfectly with his recommendations, or believes that her own methods are better, has no bearing upon the case… her sole duty is to obey orders, and so long as she does this, she is not to be held responsible for untoward results" (Robb, 250). This excerpt from Isabel Hampton Robb's book showcases the extent of the physician's authority over the nurse, patient, and the decision-making processes. It also displays the limited nature of the nurse's autonomy and responsibility within the healthcare system.

The Shifts: The Nurse-Physician Relationship

During the second half of the 20th century, there was a shift in the nurse's role from obedient physician helper to a more autonomous practitioner held responsible for all of their actions within patient care. In 1967, Dr. Leonard Stein, an experienced physician and author, wrote an article about the nature of the relationship between the physician and the nurse. It was featured in many journals, including the *American Journal of Nursing* in 1969. He described the relationship as "the doctor-nurse game" and described the game objective as avoidance of conflict or open disagreement between the two professions. "The objective of the game is as follows: the nurse is to be bold, have

initiative, and be responsible for significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician" (Stein, 699). If an experienced nurse had suggestions or helpful advice that benefitted the patient, it had to be presented to the physician in a subtle and cautious way so that the physician did not perceive the suggestion as coming directly from the nurse. In addition, if a physician wanted to ask a nurse for suggestions, it had to have been done in a way that the physician was not directly asking for it.

Stein provides an example of the game at work in his paper. A medical resident, Dr. Jones, is on-call at the hospital when he is paged at 1am. The call is from a nurse in a ward that Dr. Jones is unfamiliar with. Nurse Smith informs the physician that a patient, Mrs. Brown, is unable to sleep due to the recent loss of her father. Dr. Jones asks, "What sleeping medication has been helpful to Mrs. Brown in the past?" Since Dr. Jones is unfamiliar with the patient, he asks the nurse for advice in an indirect way. Nurse Smith replies, "Pentobarbital mg 100 was quite effective night before last." The well-informed and competent nurse forms a statement rather than a suggestion. The physician then responds in a tone of authority, "Pentobarbital mg 100 before bedtime as needed for sleep, got it,?" and the nurse thanks him in a grateful tone.

During the time of the "game", the physician still had authority, but the nurse had more responsibilities when it came to the treatment of the patient. Nurses no longer had the duty to be blindly obedient to the institution or authority figures such as physicians, but they still participated in the cultural norm of physician dominance and paternalism.

Twenty years after the original article, Stein and his researchers conducted a follow-up study and found that nurses unilaterally ceased participation in the "doctor-nurse" game (Butts and Rich, 61). They claimed independence in clinical patient care decisions, including ethical decisions.

The factors that may have led to the change in the role of the nurse include the nurse's use of dialogue, increased higher education, the nursing profession's goal of equal partnership status in the healthcare field, and alignment with the civil rights and women's rights movements (Butts and Rich, 62).

The Shift: The Nurse as an Advocate (The New Nurse-Patient Relationship)

The dynamic of the nurse-patient relationship also changed as the nursing profession became more autonomous. Nurses were assistants to the physicians, so the relationship to the patient was not a direct one. The nurse-patient relationship now possesses its own integrity without mediation by the physician's actions or presence. Most prominent of all the roles of the modern nurse is the role of the "advocate."

Advocacy, as defined by Fry and Johnstone, is the "active support of an important cause" (Fry and Johnstone, 1901). As opposed to advice, advocacy involves the nurse focusing on the patient's objectives rather than imposing the healthcare system or nurse's values onto the patient (Butts and Rich, 45). Advocacy describes the nature of the modern nurse-patient relationship and has been interpreted "as a legal metaphor for the nurse's role to the patient's human and moral rights within the healthcare system, and as the moral concept that defines how nurse view their responsibilities to the patient" (Fry and Johnstone, 1901). It is an ethical principle that justifies what nurses do in the protection of privacy, choice, dignity, and well-being of the patient (Fry and Johnstone,

1902). Advocacy requires the nurse to work in collaboration with other healthcare professionals and the healthcare system to promote the best interest of the patient. Nurses must assure that all necessary parties are involved in patient care and that the patient has all the necessary information from these other parties to make informed decisions (Butts and Rich, 26). Advocacy renders animosity toward physicians detrimental; collaboration is the key to patient success, but differences will always be found in the system. The idea of advocacy in practice can be played out in multiple ways. Nurses can empower patients by giving them the insights and knowledge needed to understand their illness in relation to the often confusing healthcare system. A nurse can also advocate for a patient by advocating for or against family, physicians, treatments, insurance companies, or healthcare facilities. This suggests that there is always an oppressive force against the patient that the advocate must resist or challenge. This new role of advocacy may seem helpful to patients, but it can also be quite problematic. Traditionally, those in need of advocacy in our society, such as young children or victims of sexual assault, are considered weak, vulnerable, dependent, and helpless. Advocacy in nursing is two-fold in that it can give hope to patients and family, but can also make the patient helpless, or seem helpless.

The Professional Codes of Nursing Ethics

Discussion on nursing ethics began soon after the establishment of modern nursing. The earliest book of ethics was written in 1900 by Isabel Hampton Robb and soon after the International Council of Nurses (ICN) developed its first code of ethics (Butts and Rich, 83). Until the 1960's, most nursing codes were physician focused because the main responsibility of the nurse was to assist the physician in an obedient

manner. All ethical situations involved how to respond to and work with the physician. In the ICN code of ethics, obedience to the physician was emphasized up until 1973, where the shift in responsibility was made to the patient (Butts and Rich, 83).

In the book, *Nursing Ethics,* Butts and Rich define ethical codes as "systematic guidelines for shaping ethical behavior that answer the normative questions of what beliefs and values should be morally accepted" but they are quick to remind the reader that all situations are different and a code of ethics, although providing useful guidance, cannot always supply exact directives (Butts and Rich, 83). It is more important to have professionals who have a basic understanding of ethics and are motivated to act morally.

Besides the ICN code of ethics, the ANA provides the other professional code of ethics. First officially adopted in 1950, the ANA Code of Ethics for Nurses with Interpretive Statements contains moral provisions and basic standards as well as specific guidelines (interpretive statements) for practice, research, education, and administration (Butts and Rich, 84). The last major revision of the ANA code of ethics and interpretive statements was in 2001 when there was a shift of focus onto the patient. Prior to 2001, the term "client" was used rather than "patient."

There are nine provisions throughout the entire Code of Ethics for Nurses with Interpretive Statements and the first three provisions focus on how to treat the patient. The first provision calls the nurse to "practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual" regardless of the status, health issue, or personal attributes of the patient (ANA Provision 1). The second provision states that the nurse's primary commitment is "to the patient, whether an individual, family, group, or community," (ANA Provision 2) creating a broad definition

of word "patient." The third provision calls the nurse to promote, advocate, and protect the patient's rights, health, and safety (ANA Provision 3). The remaining provisions are focused on the patient as well, but not as directly. Provision 5 of the code states that the "nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth." Provision 5 and the interpretive statements that follow emphasized self-respect so that care for the patient is maximized.

Self-respect is an important aspect of nursing because nurses who do not have positive thoughts about themselves may not be able to take care of their patients to their fullest capability. The ANA code also states that nurses must know the nursing profession's moral values as well as their own, and integrate the two in an appropriate way (Butts and Rich, 84). This is known as "wholeness of character" and involves maintaining integrity. To have integrity is to stay grounded in good moral reasoning, even when under criticism or peer pressure, and having the confidence to say "no" when contrary to the nurse's values or patient's interest. Nurses must keep their personal and professional integrity intact by being honest, adhering to moral and ethical principles, and maintaining moral character. A nurse must never compromise when the situation is against the nurse's personal and professional values (ANA Code of Ethics 2001). At other times though, the nurse's integrity is threatened by an outside source that the nurse cannot control. This situation often creates moral distress for nurses because they feel powerless to take the action they know to be ethically correct.

CHAPTER II

Ethical Theories and Approaches

It is important to have some basic knowledge of the different ethical theories and approaches before examining the case studies. The following sections briefly explain the nature of the theories. A deeper reflection of the ethical theories and approaches will be found in the next section along with the commentary on the cases.

Virtue Ethics

The theory of virtue ethics looks at right and wrong by focusing on the type of person one hopes to be, not the duties or consequences of one's actions. A virtuous person shows excellence in relationships and friendships, critical thinking, and community involvement. Some examples of common virtues are courage, wisdom, benevolence, moderation, truthfulness, compassion, generosity, patience, and fidelity. A nurse practicing virtue ethics would focus more on being an excellent person or nurse rather than a specific duty, outcome or consequence.

I relate to virtue ethics on a greater level than any other ethical theory. My parents have always raised me to be the best person I can be and encourage me to be a good friend and member of society. They have never condoned lying, cheating, or greediness. In addition, my parents specifically warned me to never use others for selfish personal gain. They instilled a life philosophy that recognizes the only path worth taking is one in which you never use or deceive others. I now understand that every person deserves the utmost respect and should be treated kindly.

Utilitarian Ethics

For the utilitarian, the anticipated consequences or the end results do matter when considering a decision. A person practicing utilitarianism considers the utility, or usefulness, of the consequence. A nurse using the theory of utilitarianism will hope to create a situation that promotes the greatest good, or happiness, and inflicts the least amount of harm, such as pain or suffering. The emphasis is on the collective group, not the individual, and to promote "the greatest good for the greatest number" of people. Nursing focuses usually focuses on the individual patient so utilitarian ethics may not be the best approach for nurses, but a situation will still be presented to show how a nurse practicing utilitarianism could react and think in the midst of a dilemma.

Deontological Ethics

This theory of ethics differs from virtue and utilitarian ethics because it focuses on intrinsic rightness and wrongness of actions. According to Immanuel Kant, one of the most influential philosophers associated with deontology, the consequences of ones actions are irrelevant and each being must act only from a moral sense of duty. Emotions have no part in deontological ethics. Only rational choices and reason can lead to moral actions. Nurses practicing Kantian deontological ethics would not treat people as merely a means to an end, but as ends in themselves, worthy of dignity and respect.

The Principlism Approach

Principlism is derived from a combination of utilitarian and deontological thinking in that it uses rule-based criteria that are derived from the identification of obligations or duties (Butts and Rice, 28). The basic principles are beneficence (to do

good), non-maleficence (to do no harm), justice, and respect for autonomy. The basic rules for using the principles include informed consent, truthfulness, confidentiality, privacy, and promise keeping. Principlism provides guidelines for moral decisions that help to assess the morality of actions. It is often used in ethical documents such as the American Hospital Association's Patient Bill of Rights or the United Nation's Universal Declaration of Human Rights (Butts and Rich, 28).

The Ethic of Care Approach

The ethic of care is an approach that searches for "right" or wrong" answers, but emphasizes the importance of relationships in making the decision. Originally derived from the feminist ethics of the women and civil rights movements, it functions on the understanding that relationships respond to one another. The basic beliefs are that contextual details of the situation matter and are relevant, individuals are mutually dependant in achieving interests, and vulnerable people deserve extra consideration that is measured according to the level of their vulnerability and how they will be affected by their choices. In contrast to deontological ethics, the ethic of care emphasizes that emotions must be integrated with reason in moral decision-making.

CHAPTER III

Case Studies Throughout the Lifespan

The following sections will analyze and discuss these five theories as they pertain to nursing through the lifespan in the context of case studies. The case studies used in this paper are drawn from the book, *Case Studies in Nursing Ethics* by Sara T. Fry and Robert M. Veatch. After the presentation of each case, a general commentary based on one of the five ethical theories will follow. Relevant professional traditions of the American Nurses Association in their "Code of Ethics for Nurses with Interpretive Statements" will also be used to interpret the case studies. Lastly, commentary on the nurse's relationship to the patient and physician will be provided, as well as lessons about nursing ethics that can be drawn from the case. Each of the five cases represents one part of the human lifespan and will include reproductive, infancy, adolescence, adulthood, and end of life issues.

Reproductive Issues

"The Nurse Asked to Assist in an Abortion"

Betty Phelps, a part-time nurse in a small suburban hospital, often worked in patient care areas that were short on nursing staff for any given shift. On one particular day, Ms. Phelps was asked to help out in the suite of rooms where elective abortions took place. She hesitantly explained to her supervisor that she was a devout Catholic and did not believe in abortion. She considered abortion "the killing of human life and a mortal sin."

The supervisor stated that she understood and would find another suitable nurse to cover the shift. In the meantime, Dr. Graham needed help prepping his patient and the room. Ms. Phelps was not occupied so she reluctantly agreed to help prep as long as a replacement would be sent. The supervisor assured Ms. Phelps that another nurse would be along shortly to take over her duties.

Ms. Phelps prepped Dr. Graham's patient, an unmarried 16-year-old who was eight weeks pregnant. [Although not specifically mentioned in the case study, the patient is most likely receiving a vacuum aspiration abortion. Prepping the patient would involve providing a hospital gown, giving the patient pain medications or a mild sedative, helping the patient lie on her back and adjust to the stirrups, and providing a local anesthetic to the patient's cervix.] She informed Dr. Graham that the preparation was complete, but that she would not be participating in the abortion because it was against her beliefs. Ms. Phelps assured Dr. Graham that a new nurse would be coming soon to assist him with the abortion. Dr. Graham responded with an annoyed tone and said "Do you think I have all day to wait while the nursing staff puts its moralism and emotions in order? Everyone-

the patient, the fetus, and the community- will be better off not having to deal with one more illegitimate child requiring public support." Dr. Graham also stated that there was nothing morally wrong about abortion because the fetus was just a mass of tissue and not human life. Ms. Phelps stood her ground and declined to help Dr. Graham, causing him to walk away angrily claiming that it was a "sad day for patients when nurses decided they would not provide needed care" (Fry and Veatch, 25-26).

Commentary (General)

It seems at first that this situation creates an ethical dilemma between the nurse and the physician because Ms. Phelps declines to "obey" or assist Dr. Graham. In actuality, this situation creates moral distress for Ms. Phelps because she is not in agreement with the physician about the moral standing of the fetus. Ms. Phelps believes life begins at conception and the fetus has full moral standing. On the other hand, Dr. Graham believes life begins in the later stages and a fetus at eight weeks is just a group of tissues.

Dr. Graham wants Ms. Phelps to participate for the benefit of the patient who needs care, but Ms. Phelps does not feel comfortable with abortion because of her Catholic morals. She is conflicted because her role as a nurse is to provide care and support for patients, and in this case, an abortion would be killing one of the patients (the fetus). Her Catholic beliefs and morals lead her to the conclusion that abortion is killing a patient and should not be condoned.

Commentary (Principlism)

If viewing this case from the ethical approach of Principlism, Ms. Phelps would find the ethical principles of non-maleficence (to do no harm), justice, and autonomy to be in conflict, thus creating the moral stress and anguish. Ms. Phelps' Catholicism guides her to a belief that all human life, beginning at conception, needs to be valued because it is one of God's creations. An abortion is equivalent to killing because it takes away the life of an innocent human being. To practice non-maleficence, Ms. Phelps must not take part in the abortion.

Conflicting with non-maleficence is the principle of justice. A different nurse may prioritize other principles and aim to treat patients fairly and equally, regardless of the type of care needed. Providing care for this young girl should not be any different than providing care for any other patient in the hospital. There's a further justice issue in that there aren't enough nurses working in this particular section.

Autonomy is the third principle involved in creating a moral conflict. The young patient has the right to exercise autonomy and make her own decisions. The patient has elected abortion and as a provider of healthcare under the principle of autonomy, a nurse should respect that decision, but autonomy is not one sided. The principle of autonomy involves respect for the autonomy of the professional as well, including nurses and physicians. In that case, Ms. Phelps has the right to refuse, and her decision should be respected in the same way.

Dr. Graham clearly emphasizes justice and autonomy in this particular case study, but that is not to say he is against non-maleficence. The conflict with Dr. Graham is not about the value of life because Dr. Graham clearly values life. They differ in what

constitutes “life” and what constitutes “harm.” For Dr. Graham, an eight-week-old fetus is not a human life yet. He acts out of a Hippocratic emphasis on benefiting the patient and society (Nursing Ethics, 26) and upholding the principle of justice. If the baby was to come to full term, Dr. Graham alludes to a scenario in which the teen mother suffers from having an unwanted child at a young age and must rely on public assistance to take care of the child, becoming a nuisance and burden upon society. This is his claim about justice, or social utility. Ms. Phelps is not coming from a perspective of benefits for society, but from one of personal values. Even if she agreed with Dr. Graham’s statement professionally, she views the protection of life as the priority. Her faith has clearly stated that life begins at conception.

ANA Code of Ethics for Nurses with Interpretive Statements

In this particular situation, Ms. Phelps chose to stand her ground and not assist in the abortion, even at the cost of her own moral distress. Was her decision the correct one? Is there a line that should be drawn about refusing to provide care or treatment? Situations like this are bound to affect all nurses at one point or another. Is it more important to stand up for your beliefs, or to provide for the patient, regardless of what they need? How does a nurse come to a conclusion about the right decision?

Provision 2.1 (Primacy of the Patient’s Interest) of the ANA code states that the nurse’s primary commitment is to the patient. The patient’s wishes are always valued and respected, and if conflict arises between the patient and other groups or people, the nurse is always in agreement with the patient. This provision states that Ms. Phelps duty is to

help take care of her patient- the young girl. By refusing to participate in the abortion, is Ms. Phelps denying care to the patient?

Provision 5.4 (Preservation of Integrity) of the ANA code states that nurses must remain consistent with their personal and professional beliefs and should only compromise in situations where the compromise preserves the integrity of the profession. In a situation where the nurse must care for a patient with a condition, lifestyle, or situation that is generally "stigmatized by the community and… [the nurse finds the condition, lifestyle, or situation to be] personally unacceptable, the nurse still renders respectful and skilled care," (ANA Code Provision 5.3) but if the practice is morally objectionable on a personal or professional level, the nurse has every right to refuse participation. Such refusal does not protect the nurse from formal or informal penalties, but can be acceptable when done in appropriate ways that keep patient safety intact and avoid abandonment. What is problematic here is that there aren't enough nurses, leading the physician to impugn the integrity of the nurse.

Personal values do matter in healthcare, but the question then becomes to what extent should personal values and personal integrity influence nursing practice? Could a nurse refuse to assist in the removal of a bullet because she is against the use of firearms? Granted, that is an extreme example and not completely analogous to an abortion situation, but if we all have our own personal values and morals, where should the line be drawn?

Reflection of the Nurse-Patient Relationship

The nurse-patient relationship is always of value to the nurse and in most cases, it is the priority. There will be times in practice when other values may override a nurse's duties to take care of the patient. A nurse has the right to refuse, but it should not be done thoughtlessly. In a scenario such as this, the nurse must be willing to make his or her values clear prior to the situation and work as best as they can to find a suitable replacement nurse. Patients should never be abandoned or left without care. In the case study, Ms. Phelps refuses to participate, but does so with caution. She responsibly lets her supervisor know that she is opposed to assisting in abortion. She compromises by helping prep the patient and the room, but makes appropriate plans in asking her supervisor to send a replacement. Whether the supervisor knew about Ms. Phelps aversion to abortion prior to scheduling is unclear, but now that the supervisor does know, is she responsible for remembering and helping Ms. Phelps to avoid the abortion units? Ideally, better planning ahead of time can stop the dilemma from reoccurring. This specific situation was difficult to avoid because upon arrival to work, Ms. Phelps was asked to work in the lowest staffed unit, which just happened to be the abortion unit. Her refusal created informal penalties and one of the more obvious penalties emerged in the form of hostility she was shown by Dr. Graham, but overall, refusing to participate potentially created less moral distress than if she would have decided to assist in the abortion.

Reflection of the Nurse-Physician Relationship

The nurse-physician relationship may still be strained at times and physicians still

hold authority over the nurse. If the situation was reversed, the chances of the nurse lecturing the physician are extremely low. The argument that ensued was not a reflection of academic or medical training, but one of ethical beliefs. Dr. Graham's personal ethics should not be upheld over Ms. Phelps' personal ethics, but because physicians have traditionally had authority, he addressed Ms. Phelps in a manner and tone of authority, not collaboration. Physicians have extensive years of medical training and are credible in their medical knowledge so it is appropriate to have weight over nurses in medical practice, but should that carry over into ethics? This assumption, also known as the generalization of expertise, is unwarranted because medical (or nursing) expertise does not necessarily mean moral expertise. If that were to happen to other nurses who did not have Ms. Phelps adamant beliefs, would they be able to defend themselves to someone with perceived authority?

Turning Theory into Action: What Can We Learn From This?

This case study shows the complication of nursing duties and the importance of an ethical foundation. If Ms. Phelps was not confident in her beliefs, she may have felt the pressure to assist in the abortion. Because she knew her beliefs and clearly stated them to her supervisor, she was able to help prep the patient without actually committing an act she perceived as immoral. She had the patient's interest in mind by asking the supervisor to find someone new, but she was still forced into an uncomfortable position in which her beliefs were questioned. It is important for nurses to have a solid foundation in ethical theories and approaches. Nurses should know where they stand on ethical issues and how to rationally argue their beliefs. It is better to know the nurse's stance in

advance than to find out in a moment of chaos or emergency. In addition, the supervisors and those in charge of staff assignments should be aware of such discrepancies among their nurses as to avoid future issues.

Infancy Issues

"Following the Physician's Orders: The Nurse as a Moral Spectator"

Gretchen Sears, a 20-year-old woman in mid-pregnancy, was admitted to a small community hospital for signs of premature labor and delivery. She had undergone pre-natal checkups with the local obstetrician, an elderly but well respected physician in the community, prior to being admitted, but he had not been able to determine the stage of her pregnancy at the previous appointments.

Roger Simmons, the nurse in the special care nursery and a neonatal nurse specialist, starting prepping for the possible admission of an infant at any gestational age. Mr. Simmons was new to the hospital and came from a larger medical center. He was very experienced in neonatal care so after hearing of the premature infant, he informed the on-call pediatric associate, Dr. Frank Barnes.

Meanwhile, in a different room, Mrs. Sears was informed about the risks of her childbirth. She was told that it was unlikely that the infant would be alive when it was delivered. The obstetrician warned Mr. and Mrs. Sears to prepare for the loss of their pregnancy.

When delivered, the young infant breathed spontaneously and was sent to Mr. Simmons in the special care nursery. Mr. Simmons examined the infant and found it to be 23 or 24 weeks old with no visible physical abnormalities. He assumed that the infant would be placed on a respirator and transported to a facility with greater resources. As Mr. Simmons began providing respiratory support, he was surprised to find the pediatrician and obstetrician in disagreement with his actions. Dr. Barnes said, "I'm not sure we ought to be too aggressive with this infant." In the larger hospital in which he had

previously worked, Mr. Simmons had seen infants of this size survive when intervention was quickly implemented. Dr. Barnes and the obstetrician discussed the situation further and after a few minutes, asked Mr. Simmons to discontinue any ventilation support. Both physicians believed the infant was too small to live on and thrive.

Mr. Simmons disagreed with the physicians and asked if the parents were aware of the infant's condition and its chances of survival if transported. Dr. Barnes stated that the parents would be spoken to and the obstetrician added, "Look, these parents are just young kids getting started with their lives. They don't have the resources or know-how to take care of the kind of problems this child will encounter. They'll have more babies." Dr. Barnes then asked Mr. Simmons to keep the infant comfortable and page him once the baby's heart stopped beating (Fry and Veatch, 42).

Commentary (General)

The ethical dilemma does not come from an internal ethical or religious conflict, as in the case of Ms. Phelps, but because someone else, with seemingly higher authority, has made a decision and the nurse does not agree with the decision. Mr. Simmons is the neonatal nurse specialist and is unable to walk away from the situation. He cannot leave or ask someone to fill in his place, nor does he want to. The situation makes him uncomfortable because he is unable to influence others toward the outcome that he perceives is medically right. The moral distress comes from the disagreement with the physician and the obstetrician on how to care for the premature infant.

There are a few things the case leaves unclear. It would be wise for Mr. Simmons to search for some answers in the case before making any drastic decisions. The

disagreement is over the medical judgment of the physicians, but the case does not state whether or not the physicians knew the age of the infant or were aware that Mr. Simmons did not note any visible physical abnormalities with the infant. A 24-week-old infant is premature, but still has a high probability of surviving with the right technologies. Perhaps the physicians thought the infant was much younger in age or assumed it had visible abnormalities. It would be important for Mr. Simmons to find out the exact reasons that the physicians are against providing treatment for the infant.

The case states that Dr. Barnes and the obstetrician, in the traditional positions of authority, have made the decision that aggressive treatment will not improve the health of the infant based on their own medical judgment. They believed that the infant could not survive but their reasoning behind this judgment is unclear. As mentioned before, perhaps they were unaware of the infants age and its likelihood of survival, or perhaps they considered their decision from a utilitarian perspective and believed that helping the young couple and society would be greater than helping the infant. Premature infants require money and resources that the parents may not have. They might have had to rely on society to help pay the costs of care. In addition, if the child turned out to be handicapped in some way, it would greatly infringe upon the lives of the young parents. The physicians may have believed that the infant required too much work and decided to make the executive decision to withhold treatments. Regardless of what the physician's rationale is, the real question is how Mr. Simmons will continue to function as an advocate.

Commentary (Deontological)

If analyzing this from a deontological perspective, Mr. Simmons, who believes the child could survive with the appropriate intervention, would see his duty as taking all the necessary means to preserve the life of the infant and get the family to become the decision-makers. His previous knowledge and expertise has led him to the conclusion that the Sears' infant can and would survive with better resources at a larger facility outside of the small town. He knows what options are available because he has worked in a larger setting, and he wants to take all of the measures possible to help the infant breathe and live. Mr. Simmons is a neonatal specialist, so his main patient is the infant, but in order to help the infant, the parents must be involved. Mr. Simmons wants the parents to be aware of the situation in hopes that they will disagree with the physicians and ask for care for their infant.

Mr. Simmons is experiencing moral distress because there are barriers that are getting in the way of him doing his duty as a nurse. The physicians do not agree with Mr. Simmons and are telling him not to act upon something he feels is his moral duty. Since Mr. Simmons feels that his patient- the infant- would survive, his moral duty is to do all that he can to ensure that it gets the care it deserves, and that means addressing the questionable practice of his colleagues.

ANA Code of Ethics for Nurses with Interpretive Statements

The physician's decision on how to handle the situation can be considered questionable practice because medically, it is quite clear that the infant should be receiving ventilation support. It is premature, but according to the case study, the infant

has no other abnormalities. They may have made their decision based on their small location, older age, or some other unknown reason. Mr. Simmons has a duty to protect his patient, the infant, from their questionable practice and find out why they have decided to withhold treatment because the ANA codes states, "When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice. Attention should be called to the possible detrimental affect upon the patients well-being or best interests as well as the integrity of nursing practice… if indicated, the problem should be reported to an appropriate higher authority within the institution or agency, or to an appropriate external authority" (ANA Provision 3.5). If the physicians do not respond to Mr. Simmon's inquiries and concerns, it would be wise for him to take the case to a higher authority.

Reflection of the Nurse-Patient Relationship

Mr. Simmons would act as an advocate for the infant by making sure the physicians are well aware of the infant's age, that it does not have visible deformities, and that it has chances of survival at a larger facility. Dr. Barnes asked Mr. Simmons to watch the infant while he spoke to the parents. Mr. Simmons cannot leave the infant, but at the same time, he wants to make sure the parents receive all of the information, not just the physician's biased information. Mr. Simmons could ask another nurse to watch the infant for a few minutes while he searches for the parents, or he can try to create a meeting between the physicians, parents, and ethics committee to try to inform the parents and convince the physicians to change their medical judgment. Trying to have a

meeting would be difficult, especially since the infant needs ventilation and transportation as soon as possible, but it could be done. All of this would have to be in a hurried manner so that the care is implemented as soon as possible.

Mr. Simmons demonstrates that the nurse-patient relationship is still of highest priority. He fights for the life of the child even though he stands alone against the physicians. This showcases the struggle nurses must often go through when fighting for the rights of a patient. This case also stands apart from the other cases because the patient in this case desperately needs an advocate. In most of the other cases, the patients are able to speak for themselves, but are backed up by the nurse. In this case, the patient is an infant that cannot speak or think, and must completely rely on the nurse to advocate for it.

Reflection of the Nurse-Physician Relationship

The nurse-physician relationship in this example is also highly strained because the two are coming from different perspectives medically and ethically. This case study is an ideal example of what happens when a nurse and physician disagree. Most of the time, the physician, with the greater authority (especially in a smaller hospital), will have the final decision. Mr. Simmons stated his professional opinion, which in practice might be easier said than done, and he was adamant that the infant be given care and the young couple be involved. His actions may involve having the moral courage to stand up against the physicians or let someone of higher authority become aware of the situation. A collaborative relationship is ideal in every aspect of heath care, but when a nurse must choose between collaboration with colleagues and duty to care for the patient, the patient should always take precedence.

Turning Theory into Action: What Can We Learn From This?

Similar to the first case studying featuring Ms. Phelps, this case does not showcase a situation where the physician has greater knowledge than the nurse. Mr. Simmons is rightly qualified because he is a neonatal specialist and has worked in a larger hospital. The authority of Dr. Barnes and the obstetrician is not academic, but professional. Their status as physicians, experts in medicine, and community leaders take precedence, even though their medical decision does not make the most sense. Dr. Barnes seemed to think it was acceptable, or at least permissible, to let the child die of natural causes without intervention. His ethics prioritized the quality of life for the young couple and justice for the rest of society. What if a different physician had been on-call that evening? What if that physician had an ethical framework, based on personal or religious beliefs, which aligned with Mr. Simmons? It could suggest that fate of the infant was determined by the "luck of the draw," so to speak, or the randomness of the infant's birth night and the physician who was present (Fry and Veatch, 43) or the nurse that was present.

It seems unfair for the patient to have so much discretion left to the healthcare worker that happens to be working in that patient's area during that shift. We all want to believe that physicians and nurses have the skill and knowledge to take care of us, and most rightly do, but when complicated dilemmas arise, the situation can go a number of ways depending on the ethics of that specific provider. An ethical code exists to combat this, but a code can only take one so far. How can healthcare employees align beliefs so that a patient can get the same results and options regardless of the time, place, or provider that has been assigned? Is this possible or even desired? Nurses are people, like

the rest of us, who have their own opinions and beliefs. The differences that nurses have in morals and ethics make them unique and diversify the workplace, but the role of the nurse is to always be an advocate and support the patient.

Adolescence Issues

"When It Is Hard to Keep Promises"

Peter is a young 15-year-old boy suffering from acute myelocytic leukemia. As his condition worsened, he came to realize that he was dying. His physical signs of pain, anger, and fear affected the nurses of his unit. They understood that he was dependant on others to meet his physical needs and promised that he would not suffer or be alone as his condition further deteriorated.

Peter went in and out of the hospital over a six-month period. During this time, the nursing staff grew close to him, despite his difficult attitude, attributed to his time in the foster system. His natural parents began to withdraw from him during his illness and the nurses of the hospital realized that they had become his "family." They were going to be the ones to take care of him and be with him when he died. He grew to trust and love them as they provided him care.

As his physical and emotional needs increased, it was decided that he would be assigned a primary care nurse, Sheri Martin, who would coordinate and plan his increasing amount of care. Within a few days, he was unable to walk due to the effects of his illness, and was often feverish and suffered from nausea and diarrhea. Nights were the most difficult for Peter because he feared pain, the effects of the morphine, and not waking up in the morning. He often refused his morphine and instead asked if someone could read to him and keep his mind distracted from the pain.

One evening, Peter asked Ms. Martin to stay for the evening, even though she had worked her shift during the day. There was a high probability that he was near death, so she switched hours with another nurse to stay in the unit with him. Unfortunately, another

staff nurse called in sick, leaving a shortage of nurses with an abundance of patients. Ms. Martin was conflicted over what to do. She had promised Peter that she, or another nurse, would be with him during his time at the hospital and especially at his death. At the same time, it did not seem fair to neglect the other patients who needed careful preparation for diagnostic tests the following day. These other patients needed care as well, but if no one stayed with Peter, he would feel abandoned and alone during his last hours. This would most likely cause Ms. Martin, and the other nurses, to feel intense emotions of guilt and frustration, but it is also unfair if she does not help out the other patients and nurses in need (Fry and Veatch, 115-116).

Commentary (General)

The moral distress that Ms. Martin is experiencing comes from a conflict in the allocation of resources. Ms. Martin is a nurse and knows that she is responsible for the care of all the patients present in her unit. The hospital staff is short on nurses and Ms. Martin's help would greatly improve the conditions of the hospital and the stress that other nurses and patients may be feeling. At the same time, she has made a promise to Peter and wants to keep it, especially if his life will end in the very near future.

One of the things not specifically mentioned in the case is why the natural parents have faded away from the situation. They have drawn away from Peter emotionally and don't seem to be with him physically either. Where have they gone, and how did it get to the point where the only people present at Peter's deathbed are the nurses? These are questions that Ms. Martin should try and answer if she does not already know the facts. On the legal aspect, how is the staff able to handle medical interventions or decisions if

the parents are not present to authorize it? Perhaps they are available by telephone, but do not want to physically visit Peter, or maybe they are completely out of the picture. In that case, the nurses may be considered his "family" but they have no legal authorization and are stuck in a conflict of interest.

Commentary (Ethic of Care)

There are many views that can be taken in this situation, but to analyze this particular case, the ethic of care will be used to determine the nurse's thoughts and actions. In the ethic of care, relationships are given priority over duties or obligations, and emotions are integrated into professional responsibilities. Ms. Martin has been with Peter for months and provided days of care to him. She is aware that his family has essentially abandoned him and that the nursing staff is his only true emotional connection. She promised him that she would be there for him through it all, especially during his last hours. A promise is a very significant oral and professional contract. Prior to making one, the nurse must be committed to making the promise and know that they have the resources to follow through on the promise.

ANA Code of Ethics for Nurses with Interpretive Statements

The fidelity of a nurse reflects the nurse's integrity (ANA Provision 5.3), wholeness of character (ANA Provision 5.4), and the institution in which the nurse practices. The nurse must also be accountable for his or her actions and "act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of patients" (ANA provision 4.3). Depending on

the decision, not only was Ms. Martin's credibility on the line, the hospital that she works for and the profession of nursing could have been under scrutiny. It is important for nurses to remember that their actions reflect on themselves and the profession of nursing as a whole. A few bad nurses can give the whole profession a bad reputation so it is the nurse's ethical duty to represent and advance the profession of nursing (ANA Provision 5, 7, and 9) and that involves making informed decisions about patient care.

Under the ethic of care, Ms. Martin would prioritize the relationship she has with Peter. He is alone and afraid, and as a person, she can probably relate or be empathetic to that. The other patients in the hospital, although very important, are preparing for diagnostic tests and may not be dealing directly with "life or death" situations. Although she feels it is her responsibility to help the other patients, as stated by provision 4.4 of the ANA code, Peter's emotional need would be considered greater.

Reflection of the Nurse-Patient Relationship

This case study shows that the nurse patient relationship is not often equal in energy or time. The patient has no other choice but to trust in the nurse and other members of their healthcare team. Those under the care of a nurse or physician are forced into a vulnerable situation where they must depend on another person. The patient is forced into a relationship where they must trust their health, and sometimes their life, to a complete stranger. The nurse, although having high respect and care for the individual patient that is being treated, has multiple patients throughout the day. It would be difficult to prioritize an individual patient with the time and care they deserve. In an ideal hospital setting each nurse would have to tend to only one or two patients, but the resources

involved in training and paying that many nurses is often beyond a facility's economic capabilities.

I can personally attest to this type of situation on a much smaller level. I worked at a memory care focused assisted living facility in a relatively high socioeconomic suburb of Portland. The facility had four subsections with 17 residents in each section. One caregiver was assigned to each section per shift and that one caregiver had to help feed, bathe, clothe, change, and watch over the 17 residents in each section. One LPN was present from 7:30am-2:30pm Monday through Friday, and an RN visited the facility on Monday and Wednesday evenings for a few hours. Most of the residents suffered from Alzheimer's and dementia and needed constant attention, but it could not be provided because the caregiver was always taking care of some other resident. In addition, many of the residents were in wheelchairs because they were prone to falling. The residents often forgot about their difficulties in walking, or were simply bored, and attempted to leave their chairs. Each wheelchair bound resident was connected to a tab alarm, but oftentimes the caregiver was so far away that by the time they arrived, the resident had already fallen. I experienced countless falls, injuries, and emotionally neglected residents while working in that facility.

Oftentimes a nurse will have to choose to spend time or provide more attention to one patient or another. It's not fair, but it is a situation that all nurses will experience in practice. Which situation to choose, or whom to give more or extensive care to, depends on the situation and the personal and professional ethics and principles of the nurse in question. Once that decision is made though, it is very likely that the nurse will inevitably

be under criticism for the decision either by the other patient, families, co-workers, or healthcare facilities.

Turning Theory into Action: What Can We Learn From This?

The patient is always at the center of the nurse's practice, but can a line be drawn when the patient asks for too much or the nurse oversteps professional boundaries? Ms. Martin and the other nurses cared for Peter and became a "surrogate" family for him. She agreed to take an extra shift in order to care for him in his last moments, but should that become routine practice for nurses? Should they be so involved with their patient's lives that it interferes with their own? What about Ms. Martin's family? Will they be upset by the extra hours that she is spending at the hospital? What qualities make helping one patient more desirable than another?

Part of the reason Peter is so vulnerable is his young age. At 15 years old, he was without a family to care for him emotionally and physically. He is not an adult and not capable of making adult decisions or understanding situations as adults might. Does his age make a difference in how he is treated?

We often find that the outwardly vulnerable and the ones who ask for help are the easiest to have compassion for. It is hard to care for those who seem to have it "together" or deny a need for help. They may put on an act to seem strong, or too stubborn to ask for help, but they need it just as much. It is possible that under the ethic of care, a nurse might focus too much on the outwardly vulnerable patient- the child, depressed, scared, or sad person- and not enough on the other patients who don't seem like they need it as much. In some situations, that patient might not need as much care and are okay with

attention being focused elsewhere, but other times it can be unfair, and that should not become habit for the nurse. A nurse must always remember that everyone coming in for treatment is vulnerable and in need of compassion, even if they put on an act of bravery. Deciding how to divide time and work resources requires logic and reasoning through familiarity with ANA Code of Ethics for Nurses with Interpretive Statements, and the ethical theories within nursing ethics. To navigate the decision, a nurse must have confidence in the decision, and that is where a foundation of nursing ethics will be beneficial in alleviating moral distress.

Adulthood Issues

"When the Physician Asks Not to Tell"

Nurse Patricia Alexander admits Donald Vespucci into his room after his surgery where he was diagnosed with metastatic colon cancer. Mr. Vespucci has a history of severe depression so his physician, Dr. Ernest Hester, advises the nursing staff that he will not be informing Mr. Vespucci of his diagnosis. The physician plans on giving the patient antidepressants and telling him of the diagnosis after a few days on the medications. The family members have spoken with Dr. Hester and are aware of the diagnosis and situation.

During the first two days, Mr. Vespucci constantly asks the nursing staff questions about the surgery and resulting lab work. Dr. Hester visits Mr. Vespucci twice, but still does not give him the diagnosis. The family is beginning to find it difficult to avoid Mr. Vespucci's questions and ask the nurse when the physician will be giving the patient his diagnosis. Nurse Alexander wants the patient to be aware of his diagnosis, but believes it is not appropriate or within her duties for anyone but the physician to explain the diagnosis. When asked questions by the patient, she tells him that she does not have the authority to tell him and directs him to speak with the physician. She feels caught between the patient's requests, family's request, and the physician's intended plan (Fry and Veatch, 148).

Commentary (General)

There are many points in this case that need further clarification. The case study states that Mr. Vespucci has a history of depression, but does not indicate whether he is

currently suffering from depression. The anti-depressant of choice is not mentioned so it is unclear what the risks will be to taking them. Is the physician planning on getting the patient's consent to give anti-depressants, or will he just intravenously inject them? Consent is needed, but how will the antidepressants be given without telling the patient the diagnosis? Is it even necessary to give Mr. Vespucci antidepressants? What will be the downside of disclosing the diagnosis? The physician seems to be trying to prevent depression, but it is not stated how bad the depression might become. Would Mr. Vespucci suffer from mild depression, or extreme depression that leaves him in a suicidal state? Answering these questions would help the nurse come to a more informed decision about withholding or disclosing the patient's diagnosis.

Nurse Alexander is taking part in something that Sara T. Fry, a renowned nurse ethicist, calls "benevolent deception" (Fry and Veatch, 149). Mr. Vespucci is having information withheld from him but the ones withholding the information are acting out of benevolence. According to Fry, "the central ethical question is whether either good motive or accurate judgment that the patient would be better off not knowing the news justifies the deception" (Fry and Veatch, 149). The act of disclosing or withholding information can have many consequences and they must be weighed out carefully, but even then, there are still complications and even the best health care professionals make questionable judgments.

One way in which health professionals judge the situation is the "golden rule" which forces the professional to ask, "if I were in the patient's situation, would I want to know?" There are a number of factors that cause this paternalistic judgment to be flawed, including that those in healthcare may have a different psychological makeup than the

average person. For example, Fry states that some reports find physicians to have an unusually high fear of death (Fry, 150). That would lead to more physicians withholding information from patients because that is what they would personally desire.

Commentary (Utilitarian)

From a utilitarian perspective, Nurse Alexander should continue to support the physician in withholding the information from the patient, at least for a few more days. The end result is much more significant than the way at which it is arrived. If the result is to prevent Mr. Vespucci from falling into a depressed state, withholding information from him and giving him antidepressants is the right ethical path.

The issue then becomes less about ethical issues and more about legal issues. Health care professionals have legal obligations that they must adhere to and one of the most important is informed consent. In the healthcare field, the shift has been moving toward an ethical duty to tell the truth to patients, regardless of whether it harms or benefits them. Physicians are obligated to tell the truth to patients unless they have substantial evidence to believe that disclosing the information would cause extreme harm, such as intense emotional distress. This situation is known as therapeutic privilege (Butts and Rich, 281) and was used in the case of Mr. Vespucci.

A nurse following the ethical theory of utilitarianism, might also accept a physician's flawed reasoning that patients, although competent, are more vulnerable in the hospital. Even if they had been able to handle the news well at one point, their mental stability may have decreased, and they should be cared for with greater caution. Telling Mr. Vespucci the truth would make matters worse for him and for his family. To keep his

diagnosis a secret, at least for a few days, would create the greatest good for his mental well-being and keeping him away from a depressive state, or even a suicidal state, would keep his family happier. He has cancer and that diagnosis is not going to change, regardless of whether he is told his diagnosis the day it is made or a week later. Having a patient with cancer is better than having a patient suffering from cancer *and* depression. The problem for the nurse is what is the nurse supposed to say when asked a direct question by the patient? What will the patient think by the nurse's continual evasion?

ANA Code of Ethics for Nurses with Interpretive Statements

Nurses have always held a commitment to telling the truth. The first provision and interpretive statement in the ANA codes says, "Patients have the moral and legal right… to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; … to accept, refuse, or terminate treatment without deceit…" (ANA Provision 1). It clearly states that a nurse should, without a doubt, be truthful. Nevertheless, actual situations complicate matters and the healthcare world is never black or white.

The code is meant as a guideline, but there may be times when following it to exact specifications is the wrong decision. The ANA code also states in provision 2 (ANA Provision 2) that "the nurse's primary commitment is to the recipient of nursing and health care services – the patient… nursing holds a fundamental commitment to the uniqueness of the individual patient; therefore, any plan of care must reflect the uniqueness." If there is a patient that the nurse knows very well to be unstable, such as someone with depression or a young child, the nurse can see a commitment to the

uniqueness for that patient is to maintain stability and not overload the patient's mental state with information that they would not be able to handle.

Reflection of the Nurse-Patient Relationship and Nurse-Physician Relationship

This case study shows that the relationship between nurse and patient is not as simple as it seems. Although a nurse practicing utilitarianism might not find great amounts of moral distress in the situation, nurse Alexander does have moral distress and wants the patient to know, but is caught between opposing forces- the patient and the physician. She can advocate for the patient and the family by informing the physician of their requests, but she cannot disclose the information herself if the physician has implemented therapeutic privilege. Nurses must evaluate the situation carefully with wisdom and contemplation and in most cases should avoid going against the physician's exercise of therapeutic privilege. In the rare case that the physician's judgment is absolutely unethical, the nurse could address the hospital authority figures, an ethics review board, or another physician who will support patient rights in the disclosure of the information.

Turning Theory into Action: What Can We Learn From This?

It is important to distinguish between good motive and right action. A good motive does not necessarily lead to the right action. Although the code may advise that nurses always tell the truth, there may be times when the nurse is confused about whether or not information should be disclosed. In these situations, it is important to adopt the "value system, psychological profile, and the social characteristics of the patient" (Butts

and Rich, 150) to determine the best course of action. If all else fails, the best option is to be truthful to the patient. Autonomy is so highly valued in Western cultures that withholding information, even in benevolence, is unjust. Veracity is an important aspect of the physician-nurse-patient relationship and should be honored in most cases.

End-of-Life Issues

"Family Demands and Professional Integrity"

Mr. Desmond is a 67-year-old man suffering from chronic obstructive lung disease. He has developed tracheal necrosis and paratracheal abscesses from prolonged mechanical ventilation. The physician decided that Mr. Desmond's trachea could not be repaired and discovered that he is also suffering from sepsis. Mr. Desmond is semi-comatose and unable to participate in the decision so his family, after discussing his prognosis with the physicians, decided to discontinue his treatment. The new plan was to make Mr. Desmond as comfortable as possible until his eventual and inevitable death from sepsis and respiratory failure.

Soon after the decision, Mr. Desmond's oldest daughter came to visit him. She lives thousands of miles away and has not seen him for several years. His lack of treatment and deteriorating physical condition visibly alarmed her and she began conferring with the rest of the family. She announced that the family wanted to reinstate an alternative treatment and administer massive doses of vitamins to Mr. Desmond. The physician agreed and asked Suzanne Grimes, the registered nurse assigned to Mr. Desmond, to begin the intravenous vitamin therapy immediately.

Ms. Grimes protested the vitamin therapy for the dying patient. She took her disagreement to her supervisor, but the supervisor agreed with the family and the physician. "I don't understand why you are protesting about vitamins. It won't take much to administer them, it won't cost the family a lot of money; and it might help them cope with their father's imminent death. Besides, vitamins won't hurt Mr. Desmond… he is dying anyway, so why the fuss?" said the supervisor. Ms. Grimes argued that her

objections were not about the cost of the treatment. The staff was giving the family false hopes of Mr. Desmond's survival and setting up a precedent for other families and their requests for dying patients. Ms. Grimes did not think it was a good idea or fair for families to begin making unnecessary requests of the nursing staff (Fry and Veatch, 428).

Commentary (General)

The issue that Ms. Grimes has with the new alternative plan is not the treatment of vitamins itself, but the principle behind it. Allowing the vitamin therapy to take place allows the family to take control of the situation medically and can compromise the integrity of the nurse. Ms. Grimes does not want it to become common practice for families to request any outrageous therapy or plan that they want. Ms. Grimes believes that the medical staff is highly trained and should be able to make the decisions, especially in a situation where they know that the therapy will not work at all. "The real underlying issue… may be that the professional nurse feels that her professional integrity is jeopardized if she is made to deliver a treatment that seems incompatible with her understanding of the purpose of her profession" (Fry and Veatch, 430). In assessing the situation, Ms. Grimes could argue that a family's unrealistic choice of treatment violates the rights of a practicing nurse to provide the care she's learned based on her understanding of its purpose.

This case is especially difficult because the request is coming from a daughter who lives out of town and has not invested large amounts of time or care to her father. If the request had come from the wife, or another family member involved in the whole process, perhaps the situation would be different. Why does this daughter have so much

to say and why is the rest of the family going along with her wishes? Prior to the arrival of this daughter, the family had accepted the patient's inevitable death and had agreed to make him as comfortable as possible. Another question to explore is why the physician is deciding to go along with the family's requests and what exactly the case means by saying that the patient is "semi-comatose."

Commentary (Virtue Ethics)

A nurse practicing under the influence of virtue ethics may view the situation in two different ways. If the goal of virtue ethics is to be virtuous, that is morally excellent, then does that mean one aims to be the type of person who shows excellence as a human being, or as a nurse? Of course these two aspects can be synonymous, but what if they are not?

Let us go back to Ms. Grimes. As a nurse, she could hope to be virtuous by courageously uphold the profession of nursing. If she values integrity, honesty, and moderation as a part of her virtues, she is practicing with the goal of being an excellent person and nurse who values truth. Ms. Grimes was courageous when she argued against the vitamin therapy. She did not have support from the physician or her supervisor, yet she stood up for what she believed was right. Giving the family false hope and keeping them in denial was dishonest so she did not want to participate in it. Ms. Grimes values the virtue of truthfulness, even when it is difficult to handle. Providing the vitamin therapy would violate her virtues and her professional integrity as a nurse.

In her attempt to uphold her virtues of honesty and integrity, Ms. Grimes would hope to uncover a few discrepancies. She would investigate the history of the oldest

daughter to find out about the daughter's relationship to the patient. Was it healthy, strained, or hostile? Why was she not been more involved with his care? Another important issue is why the family has allowed this particular daughter to change the medical plan when it was already decided that he would be given comfort care. Is the treatment only for the daughter's benefit in coping? Does the family understand that the vitamin therapy is medically useless?

A different nurse who also practices virtue ethics may aspire to be an excellent friend and person who focuses more on compassion and generosity. That nurse may want to follow through with the vitamin therapy, knowing well that nothing significant will change in the patient's status, simply because the nurse believes the therapy will help the family prepare for Mr. Desmond's death. The treatment may relieve the family, or perhaps just the daughter's, fear or guilt about their previous decision to stop treatment, or it might help them to not feel helpless in the situation. That nurse may reason that actively asking for a treatment, even without any type of medical knowledge or training, would be the compassionate thing to do, and it might be what the family needs for coping and death preparation in this difficult time. The nurse has compassion for the family and hopes to help them heal with whatever means are available, even if it is not the rational decision. Valuing compassion and generosity over other virtues may lead to situations that are less efficient and rational because human emotions often trump rationality.

ANA Code of Ethics for Nurses with Interpretive Statements

Interpretive statement 6.1 of the ANA code states nurses have the responsibility to uphold the values of nursing in the environment of which they practice with virtue and

excellence. Virtues help people to do what is right, while excellence helps people do a particular job or task well. “Virtues such as wisdom, honesty, and courage are habits or attributes of the morally good person. Excellences such as compassion, patience, and skill are habits of character of the morally good nurse. For the nurse, virtues and excellences are those habits that affirm and promote the values of human dignity, well-being, respect, health, independence, and other values central to nursing” (ANA Provision 6.1). Nurses must also be responsible and accountable for their individual nursing practice. The ANA code says the tasks a nurse performs must be consistent with the nurse’s obligations to provide optimum patient care (ANA Provision 4). What constitutes “optimum care” is a debatable topic, but most people would agree that a treatment that does not benefit the health of the patient would not be considered “optimum.” Under Provision 4 nurses are also accountable for all the care they give so providing a treatment that does not conform to the standards of nursing care could very well make a nurse feel uncomfortable.

At the same time, Provision 2 of the code states that the nurse’s primary commitment is to the patient. In the case of Ms. Grimes, Mr. Desmond is unable to provide any direction so the family has become his proxy. They are adamant about the vitamins and demand that they are administered. Provision 2 could be interpreted in a way that requires the nurse to honor the family’s requests.

Does commitment to the patient mean the nurse should cater to every wish and command of the patient and family? If the patient is going to die, is it more permissible to give the patient and the family everything they desire? If Mr. Desmond was conscious and well aware of his prognosis, but still asked for the vitamin therapy, would Ms. Grimes be more or less opposed?

Reflection of the Nurse-Patient Relationship

This case helps us to ponder whether it is right to do everything we can to make the patient or family content. The nurse will do the nurse's job, but is it ethically required to do more than that? The job must be done in a compassionate manner and to maintain human dignity, but is it morally wrong to refuse to provide a medically useless treatment, even if the family demands it or will find that it is emotionally useful? Perhaps it is better to be honest and forthright to the family or patient, informing them that the therapy is useless and would not provide any changes in the patient's condition; or maybe it is more compassionate and caring to go along with the minimal requests of a grieving family.

Reflection of the Nurse-Physician Relationship

The nurse-physician relationship in this case is not characterized by teamwork or collaboration because the physician makes a unilateral decision. He makes the decision without consulting Ms. Grimes and does not seem to care that Ms. Grimes opposes the therapy. What if Ms. Grimes and the physician had been on the same page? Would the situation have turned out differently? Ms. Grimes experiences moral distress in the situation because she is unable to maintain her professional autonomy and make the decisions that she views are appropriate and ethical. The physician and family order her to administer a treatment that she does not agree with and her nursing supervisor does not support her in refusing the treatment to maintain her integrity. Ms. Grimes is left with nothing but a feeling of disempowerment.

Turning Theory into Action: What Can We Learn From This?

In this case we find a nurse that believes her nursing duties are being compromised, yet does not have any support in dealing with the moral distress. She feels as if the family, physician, and supervisor have all allied together and she is the lone nurse that is refusing the vitamin therapy. A nurse may encounter this type of situation in practice but should not be discouraged over the lack of support. Maintaining and protecting one's integrity may often involve standing alone against the opposition. It is important for a nurse to maintain personal and professional integrity in the situation and search for alternative solutions so that the nurse can still be an advocate for the patient. For example, Ms. Grimes could try to bring the family, physician, and a counselor together to try and work through the situation. The medical staff could inform the family that they recognize and appreciate their concern, but Mr. Desmond is an irreversibly dying patient, and the vitamin therapy is medically useless. The counselor could try and uncover the family's motives behind demanding the treatment and help them cope with the upcoming death in a more appropriate manner. Many things can be done and should be considered before compromising personal and professional integrity, but it should always be done with the patient's best interest in mind. The nurse should continue to be an advocate for the patient in all that he or she does.

CONCLUSION

Personal Reflections

Through the examination of the five case studies, I have confirmed that I relate the most to theory of virtue ethics, but I have also discovered that I have a strong connection to the ethic of care. I have always emphasized relationships in my personal life, but not until I researched the ethic of care did I realize that I could incorporate it into my professional life. I found a few of the cases difficult to analyze because I automatically wanted to look at them from a virtue or ethic of care approach. It took strenuous critical thinking, and plenty of outside help, for me to analyze the cases from perspectives that I had trouble relating to.

This project has achieved two things for me in regards to my aspirations to pursue nursing. The first is that I am now more confident than ever that nursing is the career I hope to settle into. I also know the lifespan areas that I find the most interesting. I was drawn to the cases about children more than the adult or end of life issues. I found myself working on cases about children with much more passion than I had with other parts of the lifespan. The cases were not necessarily easier to work through, but I enjoyed analyzing them more than other types of cases.

The second byproduct of this project is that I am more anxious of the types of ethical dilemmas and moral distress that I may encounter in practice. I only analyzed five cases, but I read over 50 different cases before choosing specific ones. Reviewing the different scenarios and all of the moral distress that other nurses went through and it makes me a little hesitant, but I know that there is not a single job in the world that is

perfect. I believe that the positive reinforcement I will receive from a career in nursing will be greater than the moral distress that I will encounter.

Working through the case studies has also broadened my scope and helped me in my critical thinking skills. I noticed that I tried to solve the moral distress of cases in one way, and as I started noticing patterns in my writing, I realized I was not stretching myself, or my reflections far enough. I started looking at other sources and tried to learn how else to view and handle the dilemmas in the case studies. It has led me to new skills and resources in my ethical reflection and critical thinking.

The Value of Nursing Ethics and Ethical Reflection

There is an immense value for nurses to have ethical reflection in their personal and professional lives. Reflections open our eyes to things we may not have seen the first time around. With ethical reflection and critical thinking in the personal and professional realm, we can learn from our mistakes or reinforce the good that came from our successes. Ethical reflection can also help nurses to identify personal biases or unhealthy patterns of practice or thought. In day to day practice, the nurse will most likely make ethical decisions without experiencing moral distress, but every once in a while a dilemma will occur. Unless the nurse is familiar with ethical reflection, the situation may cause more moral distress than necessary. Nursing ethics really do prepare a nurse for the healthcare world because it gives the nurse a moral foundation.

Being able to participate in ethical reflection can also help nurses learn about their own personal ethics. Some may argue that ethical reflection and nursing ethics get in the way of nursing. It might make nurses “over think” when the situation calls for “gut” reactions. Perhaps this is true for some nurses and they work better when following their

natural instincts, but I personally value analyzing and taking time to think (if it is appropriate in the situation) because I know myself well enough to understand that my first reaction may not always be the most rational. This project has helped me learn about professional nursing ethics, but it has also helped me in establishing and confirming my own personal ethics. I would not have been able to do that without ethical reflection.

Future Directions

The following sections are questions and thoughts that I have come across during the reflection of my thesis.

In the introduction, it was mentioned that nursing has roots in the Judeo-Christian beliefs of moral virtue, duty, and service to others. Like almost everything else in the US, healthcare and nursing has become more secularized and Judeo-Christian values are no longer taught in nursing schools. However, moral virtue, duty, and service to others still remain at the core of nursing. What has replaced religion in nursing? Did it happen over time, or in a specific era? Has the shift from religious traditions to secularism affected nursing in any way?

Another point I would have liked to further explore is the role of the nurse as an advocate. Based on the readings and research that I did, I think the advocate model has, for the most part, dramatically changed the profession of nursing for the better. The advocate model can misrepresent the patient as needy and vulnerable, but overall it seems that the role of advocate is appreciated by, and works in favor of the patient. In the case studies, when conflict arose, the nurse usually advocated for the patient against other sources. At times that the nurse had a personal conflict, such as the abortion case, where the nurse chose personal ethics over the patient, but even in that case, the nurse still

supported the patient by prepping her and the room. The nurse in all five of the cases never abandoned the patient and worked for the good of the patient.

The relationship of the nurse and the physician was often shown as strenuous in the cases that were presented. Difficulties will surely arise between the nurse and the physician, but the important thing to keep in mind is the patient. Oftentimes, the patient is the one who will be hurt by a hostile relationship between a nurse and a physician. The nurse should always have a collaborative relationship with the physician, and other colleagues, to maintain the best result for the patient. If an issue does arise, it should be ethically reflected upon to see whether it is a personal issue or professional one. The patient should be considered in whatever the nurse decides and the nurse should work to advocate for the patient, if possible, and minimize the moral distress.

Another question to consider is whether one ethical approach is better than the other when it comes to nursing. It seems to be that all situations are unique and that there never is an exact format to follow. When it comes to nursing, most of the approaches and theories worked for the nurse. I found utilitarian ethics to be the least relevant to nursing because it focuses on the group rather than the individual, and this creates an issue because nursing is so patient based. There are times that utilitarianism could work, but in general, that theory does not seem to fit into nursing as well as the other ethics. Perhaps the best approach for the nurse is using the ethic of care. A caring relationship is the defining aspect of the nurse-patient relationship. Patients expect to have loving and compassionate nurses who will advocate for them and be on their side. An ethic of care seems to fit this image well. Virtue ethics also fits well in professional nursing ethics. I

find virtue ethics to be present in many of the codes, especially pertaining to the virtue of truthfulness, in the ANA Code of Ethics for Nurses with Interpretive Statements.

Another possible argument is that some ethics work better with specific areas of the lifespan. For example, perhaps deontological and virtue ethics are better for adulthood or geriatric nursing because it emphasizes the duty of the provider as well as patient autonomy. These theories may not be as significant in pediatric nursing. Perhaps the ethic of care is an approach better suited for end-of-life issues. When it comes to death and dealing with death, it seems to be that most people decide rationality, duty, or utility does not matter as much as relationships and emotions.

For some, choosing one ethical approach is ideal and for others it may depend on the age of the patient, but I think the better approach is to have an understanding of all of the ethical approaches and decide as the situation arises. The ethic of care may not work for the case of every child or every end of life patient. The healthcare world is gray, extremely gray, and there are a number of different scenarios that could arise. The ethical theory to use can vary from case to case and the best way to know how to handle moral distress is to have a clear understanding of the ethical approaches and theories.

Some nurses may question whether learning and understanding the general ethical theories is actually necessary for nursing. Would it be more efficient and better suited for a nurse to just follow the ANA Code of Ethics instead of learning about the different ethical theories? The ANA code is a specified code for the entire profession and it lays out specifics for the nurse in the interpretive statements. What more is needed if the ANA Code lays out all of the details? Something I found during the course of my case studies was that the provisions of the ANA sometimes contradicted each other. One code would

tell the nurse to act a specific way, while the other would imply a different response. The result came down to how the individual person interpreted the provision. Although the code has specific interpretations, ethics will always be ambiguous, and that is why I think it is important to incorporate the general ethical theories into nursing practice. When the code is unclear, which may or may not happen often, the best solution is to have a nurse that is motivated by personal ethics to act morally. The general ethical approaches are important to personal ethics, and having personal ethics supplements professional nursing ethics to create the most well rounded nurse.

A well-rounded and ethically educated nurse is who I hope to be and this thesis has helped me grow in my personal ethics and ethical reflection skills. I look forward to using what I've learned and experiencing ethics firsthand during my future practice as a nurse.

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