Applied Ethics in Nursing

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SPRINGER PUBLISHING COMPANY
New York
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Contents

Contributors ix
Preface xiii

Part 1: The Essence of Ethics and Advocacy in Nursing 1

1. Defining Ethics and Applying the Theories
   Michael Dahnke and H. Michael Dreher 3

2. Knowing When and How to Advocate
   Martha Turner and Moni McIntyre 15

3. Informed Consent: Ethical Issues
   Susan B. Dickey 25

4. Patient’s Rights and Ethical Issues
   Eileen Mieras Kohlenberg 39

5. Research in Human Subjects: Ethical Issues
   Rose H. Mueller and Cindy Stern 47

Part 2: Ethical Issues at the Beginning of Life 59

6. Genetic Technology: The Frontiers of Nursing Ethics
   Ellen Giarelli, Dale Halsey Lea, Shirley Jones, and
   Judith A. Lewis 61

7. Reproductive Technology: Ethical Issues
   Mary E. English 81

8. Ethical Issues in the Care of Neonates and Infants
   Anne M. Lovell 99

9. Ethical Issues in the Care of Children
   Lauren G. McAliley 111
Part 3: Ethical Issues With Vulnerable Patients

10. Psychiatric Patients and Ethical Issues  
   Deborah Antai-Otong  
11. HIV-AIDS Patients and Ethical Issues  
   Diane E. Radvansky  
12. Diseases Where Patient Behaviors Are a Key Factor: Ethical Issues  
   Doris V. Chaplin  
13. Long-Term Care Patients: Ethical Issues  
   Diane Stillman

Part 4: The Right to Live and the Right to Die

14. Ethical Issues in Organ Transplantation  
   Carolyn H. McGrory and Linda Wright  
15. End-of-Life Ethical Issues  
   JoAnne Reifsnyder, Vicki D. Lachman, Terri L. Maxwell, Margaret M. Mahon, Catherine S. Taylor, Sally J. Nunn, and Ursula H. Capewell  
16. The Right to Die: Ethical Issues  
   Sally J. Nunn, Vicki D. Lachman, Margaret M. Mahon, Catherine S. Taylor, Terri L. Maxwell, Ursula H. Capewell, and JoAnne Reifsnyder

Part 5: Developing an Organizational Culture That Supports Ethical Behavior

17. Access to Care and Ethical Issues  
   Caroline Camuñas  
18. Organizational Ethics  
   Mary Lou Helfrich Jones  
19. Leadership Ethics  
   Kathy Malloch  
20. Labor Ethics  
   Vicki D. Lachman and Julia W. Aucoin  
21. Ethics Committees  
   Barbara B. Ott
Part 6: The Mix of Culture and Religion With Ethics 275

22. Religion and Ethics 277
   Syvil S. Burke

23. Culture and Ethics 289
   Joyce Bedoian

Appendix: ANA Code of Ethics for Nurses 297

Index 299
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Preface

*Applied Ethics in Nursing* is designed to give practicing and student nurses an easily understandable guide to the kind of everyday ethical dilemmas they may face. The book uses a question and answer format along with numerous case studies to present best practices and strategies for approaching the difficult problems commonly found in clinical practice. It also addresses organizational and institutional issues that can confound or promote ethically sound decision making. The question-and-answer and case study format is used so that ethics is discussed in the context of “real-life” situations. Each chapter ends with a resource list of websites and recommendations for further reading. The American Nurses’ Association *Code of Ethics for Nurses* is used as a guide throughout, along with standards and guidelines from other major health care and governmental organizations.

Chapter authors were selected for their expertise in their respective specialties and a knowledge of typical ethical problems found in these areas. They derived the questions and cases for their chapters from three methods. In some cases, they conducted focus groups with clinical nurses to develop situations commonly encountered. Authors also searched the literature to determine the most often discussed issues. Finally, authors worked with other experts in their field to determine the key information needed by practicing nurses in that specialty. Most chapters were developed with a combination of these three methods.

The book is divided into six parts. After establishing basic principles of ethics in Part I, a developmental perspective is used for Parts II through IV, in which ethics is presented in terms of specific life stages, from pre-conception and the beginning of life to end-of-life issues. Vulnerable populations with special ethical considerations, such as individuals with HIV/AIDS or mental illness, are included in Part III. Part V discusses developing an organizational culture that supports ethical behavior. Part VI examines specific responses of patients from different cultures and religions.
Some of the ethical issues and practical strategies for action in this book include:

- What exactly are “patient’s rights” and how do you advocate for your patient?
- What is “informed consent”? What can I do if the patient lacks the capacity to make decisions?
- What is the rationale for giving a patient medication (chemical restraints) against his or her will?
- Do healthcare workers have the autonomy to refuse to care for HIV-positive patients if they believe their safety is at risk?
- How should staff handle refusal of treatment, whether it is refusal of medications or even refusal of personal care?
- Is there an internationally accepted definition of death?
- Is it ethical to ask a family to donate a loved one’s organs when they have just been traumatized by the potential donor’s death?
- What should a nurse do when physicians avoid approaching a family with a patient who has a poor prognosis?
- How should I respond to a patient who requests my help in dying?
- How should a professional nurse manage a situation when a colleague/peer delivers substandard care?
- What is the role of the ethics committee?

I hope you find *Applied Ethics in Nursing* an enjoyable book to read and a reference book you will turn to repeatedly. This down-to-earth, practical approach should help you manage ethical issues in an array of clinical settings, as well as provide you with strategies to manage organizational and cultural problems. I believe this book provides you with the needed guidance you desire.

Vicki D. Lachman, PhD, MBE, APRN
Part 1

The Essence of Ethics and Advocacy in Nursing

Part 1 begins with an overview of moral reasoning and the application of ethical theories to nursing practice. Understanding advocacy responsibilities and needed skills is followed by a focus on the importance of the nurses’ support in the informed consent process. The chapter on Patients’ Rights examines the multiple documents on this subject, as well as typical rights issues nurses confront. Finally, Part 2 ends with the application of these skills in the arena of research on human subjects.
Chapter 1

Defining Ethics and Applying the Theories

Michael Dahnke and H. Michael Dreher

1. What is ethics, and why do nurses need to understand it?

“Ethics” is commonly defined as the philosophical study of right action and wrong action, also known as “morality.” Being “philosophical” does not mean that ethics is a study of or concern only to philosophers. Any human being at one point in his/her life has pondered questions of right and wrong.

It would be helpful for a nurse to understand ethics because nurses encounter many of the same ethical problems and questions as any human being. However, beyond that, because of the nature of their work, there are specific moral questions and problems that arise: questions of confidentiality, patient rights, questions of life and death. An understanding of ethics can help a nurse get a clearer view in these difficult cases of the issue at hand, the possible courses of action, and the principles underlying right action.

2. When ethics and the law appear to be in conflict, which is more important for the nurse to follow?

This is a very complicated question with no single answer. The law and ethics are not the same but often overlap and both should be taken into
account in making difficult decisions. Law describes the minimum standards of acceptable behavior. Ethics delineates the highest moral standards of behavior. One might say, however, that morality is broader and hence more primary. The law does not specifically encourage us to act morally. However, many philosophers believe there is, or should be, a moral basis to the law and that we have a *prima facie* moral obligation to follow the law.

### 3. What does it mean to have a *prima facie* moral obligation to follow the law?

*Prima facie* is Latin for “at first sight,” meaning in this context, “evident or true absent any further considerations.” That is, some moral or legal obligations may be overridden by more pressing or important (overriding) obligations. For example, a *prima facie* moral obligation to follow the law means that in a presumptively just society laws are presumed right, proper, and good for the society. However, they are not absolute and, under the right conditions, can be overridden by concerns that are more important. Such a conflict, then, may present us with a kind of ethical dilemma.

For example, this Registered Nurse author faced such an ethical dilemma when caring for a critically ill elderly patient in the CCU years ago. When this patient suddenly arrested, the code response team had a *prima facie* legal obligation to resuscitate him, as he had “full code” status. However, the wife was in the room at the time of the cardiac arrest and she threw herself on top of her husband as the code team entered the room, begging them to “let her husband go in peace.”

### 4. What does the term “ethical dilemma” mean?

A dilemma is defined as a problem that confronts one with a choice between options that seem or are equally unfavorable. For example, in the case of a patient in a persistent vegetative state one might face the decision between prolonging what appears to be a life with no “quality” and little or no reasonable hope of recovery, and allowing the patient to die on his/her own. This dilemma would obviously confront the physicians, the parents, and other loved ones of such a patient. However, this would be of concern for nurses also (or especially), as families often turn to nurses first for help and comfort in such situations.

### 5. What is the difference between a moral dilemma and an ethical dilemma?

The terms ethics and morality, as most people and some philosophers use them, are generally synonymous. However, there are philosophers who
distinguish between ethics and morality, using “morality” to designate the conventional beliefs that a particular society holds and “ethics” to refer to the rational study of beliefs in general. This distinction allows us to refer to a problem as a moral dilemma but recognize a possible, reflective ethical resolution to it. An “ethical dilemma” then might be considered a higher order problem on a more theoretical, less practical, level.

6. What is the process a nurse should use to resolve a moral dilemma?

It is possible many moral dilemmas will never be fully resolved, but there are methods for coming to a clearer and deeper understanding of the issues at hand. Once this depth and clarity is achieved, an answer may present itself that is not perfect or ideal, but more considered and possibly less undesirable. Let us examine the ethical dilemma surrounding the wife and her husband’s code status.

In this case, with the patient in obvious cardiac arrest, there was no time to convene a full ethics board review. The primary care RN did inform the responding MD that the patient was critically ill, had a “full code” status, and the wife was the sole legal representative. The team was obviously in a quandary about whether to literally peel the wife off her husband’s body and resuscitate him or to adhere to her wishes. In this case, the primary care RN quickly contemplated the many possible outcomes. What if the patient died and the wife recanted her story? What if her attorney said she was under duress, not using sound judgment, and we had a *prima facie* legal obligation to resuscitate him? What if the wife reported the primary care RN to the State Board of Nursing?

On the other hand, what if suddenly adhering to her request was indeed the most moral action to take and the most humane? With little time to spare, the entire code team looked to the primary care RN for guidance, as this RN and the responding MD had the most to risk in this situation. Still weighing the pros and cons and the risks and benefits (albeit quickly), the primary care RN decided to follow the wife’s sudden request. He suggested the responding MD quickly write a “no code” on the patient’s chart, and then come back and pronounce the man. The entire code team looked at each other, not knowing really what to do next, and then the nursing supervisor and responding MD concurred. As Pastoral Care arrived, the patient died in peace, was pronounced, and no party took further action. The dilemma was resolved.
7. How does the nurse know if he/she is using good moral reasoning?

As you practice moral reasoning, you will see for yourself issues becoming clearer and the distinction between clear and fuzzy reasoning becoming more evident. This is not very different from the phenomenon in which the study of basic arithmetic aids one in eventually understanding higher mathematics. However, moral reasoning rarely if ever provides as clear and unequivocal an answer as mathematics usually does.

In the above case, the primary care RN did know that while adhering to the wife’s request had real risks, it was the right thing to do. The primary care RN also had support, as the entire code team also agreed to not resuscitate the patient and let him die peacefully. In this case, the entire team probably thought they had used “good moral reasoning.”

8. What is the purpose of a professional moral code like the American Nurses Association (ANA) (2001) Code of Ethics for Nurses?

Considering the great deal of time and thought that members of the profession invested in the development of this code, a nurse should approach it with a presumption of moral correctness. That is, presume that there is guidance and wisdom to be found within. But remember, these codes are not to be blindly followed but are meant to assist in making decisions, not as a manual to be consulted for easy answers. Countless atrocities have occurred throughout history because individuals blindly followed rules and then used those rules in order to deflect moral responsibility later.

The Code is an ethical standard and delineates the ethical obligations of all nurses. It provides a framework for ethical analysis and decision. If the nurse cannot in good conscience abide by the provisions of the Code, he/she needs to seek guidance. It is a dynamic document, so as changes occur in the social context, so may the Code change. It is a document that demands of the professional nurse to think critically and to honor autonomy of self and of patients. The principle of autonomy implies at least two distinct claims:

1. The autonomous individual deserves respect as a rational person capable of making his/her own decisions, and, thus, should be allowed to do so.

2. Since the autonomous individual can make her/his own decisions, he/she is responsible for those decisions. By practicing good moral reasoning, you are cultivating autonomy.
9. **Is it possible to have right and wrong answers using moral reasoning?**

It is true that there is a significant subjective element to morality, but one can also use objective elements when rationally attempting to solve a moral or ethical dilemma. Moral philosophers distinguish between descriptive statements that establish the facts of a case and normative statements that determine values. Obviously, descriptive statements have a primarily objective nature and, thus, are subject to rational determination. But even values, which are much more subjective than facts, can be subject to some degree of rational consideration if we determine what results might flow from those values.

One example of this is an individual nurse’s belief about assisted suicide. One nurse might have a religious belief that this act is always wrong. A non-religious nurse might believe the act may have real merit in special cases. Nevertheless, this act is illegal in 49 of 50 states in the US and even the Oregon law does not allow any nursing participation in this procedure. Therefore, it may be perfectly fine for a nurse to be sympathetic to a patient’s request, but the act would have serious legal consequences in all 50 states. In this case the question remains whether complicity here is morally wrong, regardless of the legal implications.

10. **What is the role of religion in answering moral questions?**

Religion is a guide for morality for many people. There is nothing inherently wrong in this approach to morality, but it does have its limitations. First, in a multicultural society it would be unreasonable to expect everyone to share your religious and, hence, moral convictions. Applying such a morality in a public setting can lead to a form of imposing one’s beliefs (religious/moral) upon others who may have equally as strongly held religious/moral beliefs and are under no obligation to accept yours, which may clearly lead to ethical dilemmas. More importantly, since most religions establish moral principles in a dogmatic, commandment-like form, there usually is no room left for rational consideration. Thus, when facing a dilemma most religious morality may be found lacking the proper intellectual tools for handling these “hard cases.”

11. **What is “ethics of care”?**

Ethics of care is a recently developed moral theory originally based on the insights of moral psychologist Carol Gilligan who claimed that women
understand ethics differently from men. The philosophers who developed the theory rejected the traditional male-centered ethics that focused on rationality, individuality, and abstract principles in favor of emotion, caring relationships, and concrete situations. Philosopher Nel Noddings sees caring ethics as reflecting an image of human connectedness. She described personal relations as “ontologically basic and the caring relation as ethically basic” (Noddings, 1984, p. 3). In caring for others, we aspire to be our highest self.

Some in the field of nursing ethics have suggested this theory as particularly suited for nursing, but others find this theory problematic. Kuhse and Singer (2001), for example, in criticism of the theory warned that an ethics focusing entirely on the nurse/patient caring relationship risks the perpetuation of stereotypes, unequal gender roles, and oppressive, even abusive, “caring” relationships. These authors also claimed that the theory risks the loss of the nurse’s moral voice (on the behalf of the nurses themselves as well as the patients), that the subjective nature of the theory does not allow for universally accessible moral principles, and that it neglects potentially important moral principles like justice.

Gilligan’s “ethics of care” also raises questions about the ability of male nurses to care. Do male nurses care “more” than men do in general, or do they care differently than most men because they have been socialized to “nurse”? Alternatively, do male nurses “not care” differently from men in general?

12. What is utilitarianism and how would I use this theory in practice?

The guiding principle of utilitarianism is what is called the “principle of utility” or the “greatest happiness principle”: those actions are to be chosen which will produce the greatest amount of happiness for the greatest number of people. The concept of triage is based upon this form of thinking: doling out limited resources (e.g., time, medication) based on greatest need and a capacity to benefit from the resources. When faced with a decision which will result in pain and/or pleasure (those are the elements that comprise the utilitarian understanding of happiness), a nurse could be justified in choosing the alternative that results in the greatest amount of pleasure or least amount of pain. A utilitarian approach can also be seen in the ANA (2001) Code’s stated purpose as “an expression of nursing’s own understanding of its commitment to society” (p. 5).
13. What is pragmatism and how does it differ from utilitarianism?

Pragmatism is an American school of philosophy that rejects the esoteric metaphysics of traditional European academic philosophy in favor of more down-to-earth, concrete questions and answers. Pragmatist philosopher John Dewey developed a method of moral problem solving based on the scientific method, which very closely resembles the nursing process. Pragmatists contend the only reason people have for calling one view true and the other false is that one works in the human experience and the other does not. Miller and colleagues (1997) have adapted this method for clinical ethics into a four-step process:

1. Assessment
2. Moral diagnosis
3. Goal setting, decision making, and implementation
4. Evaluation

First, assess the facts of the situation; second, diagnose the moral problem; third, set goals and decide on a plan of action, which is then implemented; fourth, evaluate the results. Rather than allowing oneself to get caught up in esoteric quandaries of moral theory, this method provides a clear, straightforward, even democratic, approach to moral problem solving that may not always result in clear, unequivocal answers but increases the likelihood of clarifying the situation and achieving a resolution. Pragmatists believe we are in a continuous quest for workable solutions to difficulties.

14. What is deontology and what does it have to do with ethics and nursing?

Deontology is an approach to ethics that focuses on “duty,” which, in fact, is what the Greek word “deon” means. Deontology is often contrasted with consequentialism, which judges actions from their consequences, not from the intent of the action. Immanuel Kant was the major proponent of deontology. In differentiating a moral action from an immoral one, a good person acts from a sense of duty, not from inclinations and feelings. An individual would repay debts not to avoid punishment but because it is the right thing to do.

For example, a nurse might attempt to justify informing the spouse of a patient with a communicable disease against the patient’s wishes in order
Part 1: The Essence of Ethics and Advocacy in Nursing

10 / Part 1: The Essence of Ethics and Advocacy in Nursing

to prevent cross-infection of the spouse. The nurse has a duty to protect the patient’s confidentiality and also a duty to protect the public. She would need to inform the patient of her duty to report (mandated by state). She should also encourage the patient to discuss it with his/her spouse.

Provision 2 of the ANA (2001) Code defines the nurse’s paramount duty as commitment to the patient. Section 2.2 states, “Nurses . . . must seek to ensure that employment arrangements are just and fair and do not create unreasonable conflict between patient care and direct personal gain” (p. 10), which outlines a sense of duty that places the patient first, ahead of a nurse’s personal gain.

15. What is virtue theory?

Virtue theory is the ethical theory probably least used in the consideration of professional or applied ethics, which is unfortunate. The reason for applied ethics’ general neglect of it is probably that unlike deontological theories or consequentialist theories, virtue theory is not geared toward answering specific questions, or making specific ethical decisions. Rather, virtue theory, as originally developed by the philosopher Aristotle, aims toward the cultivation of good character. If one learns and practices virtues (e.g., honesty, courage), one will develop good character from which will flow good actions and good decisions. The cultivation of good character would be valuable to nurses as they grow themselves within their profession. If they work to instill virtues within themselves, good actions and decisions are more likely to follow. If they fail to do this, sloppy thinking and ill-considered decisions are likely to follow. Aristotle based his choice of proper virtues on those that tend toward the proper good of “man.” We can appropriate this way of thinking and determine that the proper virtues of nurses are those that will tend to create the best nurses.

16. What does the term bioethics actually mean?

Bioethics is the subdiscipline of applied ethics that studies the moral questions surrounding biology, medicine, and the health professions in general. It is a term sometimes used interchangeably with “medical ethics,” but more appropriately, bioethics is a broader category that would include medical ethics. The issues explored by bioethicists include questions of research ethics: the use of patients in clinical drug trials, stem cell research, human cloning; questions of medical ethics: patient autonomy, euthanasia, abortion, gene therapy, and broader social questions: genetic testing, the
role of physicians in society, the commercialization of health care. This, of course, is not a complete list, but merely a sampling of the many issues and questions addressed in the study of bioethics.

17. What does the term justice mean?

Harvard philosopher John Rawls (2001) provided a brief definition of justice in one of his works: “the elimination of arbitrary distinctions and the establishment within the structure of a practice of a proper share, balance, or equilibrium between competing claims” (p. 191). According to the concept of justice, then, there is a certain inherent rightness or wrongness in actions based on fairness in distribution. That is, someone receiving a punishment equal to the crime he/she committed is receiving a just punishment. Someone receiving back money lent out is being treated justly. Someone keeping money spewed out by a malfunctioning ATM machine, however, is being unjustly rewarded. Nurses may find themselves facing questions of the just distribution of health care, especially regarding the question of income level as an arbitrary distinction in relation to healthcare distribution.

18. What is a “right” in ethics?

A “right” is a claim someone holds, which imposes a duty upon others. For example, in the practice of nursing, most patients would probably say they have a right to unconditional care from a professional nurse. A nurse might likewise believe he/she has a right to advocate on the patient’s behalf.

Rights are often described as positive or negative. “Negative” rights are rights of noninterference, meaning that all that is necessary for you to enjoy your right is for others to leave you be. “Positive” rights are rights that impose affirmative or active duties upon others. For example, if health care were seen as a positive right, then a form of universal health coverage would seem to be obligatory. If health care were seen as a negative right, one could seek out health care freely and without his/her rights violated as long as no one inhibits or prohibits him/her from doing so. Section 3 of the ANA (2001) Code imposes a duty upon nurses to safeguard several rights of patients: privacy, confidentiality, and self-determination.

19. How can I use ethical reasoning in my practice as a nurse?

Although the various theories may seem to conflict and even contradict, some philosophers suggest seeing them as wells we can draw from depending
on the needs of the situation we find ourselves in. Utilitarianism can keep us mindful of the importance of the consequences of our actions, the effect these actions have on others, and the duty to minimize suffering. Kantian ethics can keep in front of our eyes the importance of dignity, autonomy, and responsibility. By developing the virtue of courage, we can better advocate for patients. In addition, perhaps, most directly regarding the specifics of this question, Dewey’s pragmatist ethics can remind us of the constantly changing nature of the human experience, which brings with it the need for a flexible and evolving approach to ethics.

**Resources**


**GLOSSARY OF ETHICAL TERMS**

1. **AUTONOMY**—right to self-determination; being one’s own person without constraints by another’s actions or psychological and physical limitations.

2. **BENEFICENCE**—duty to do good.

3. **CONFIDENTIALITY**—holding information entrusted in the context of special relationships as private.

4. **FIDELITY**—duty to keep one’s promise or word.

5. **GRATITUDE**—duty to make up for a good; what do I owe?
6. JUSTICE—treating people fairly; equitable distribution of risks and benefits.

7. NONMALEFICENCE—duty to do no harm.

8. REPARATION—duty to make up for a wrong.

9. SANCTITY OF LIFE—the standard that life is precious. This standard is used for appraising other ethical principles. No human rights and no valuation of human life can be established without presupposing this principle.

10. UTILITY—doing the greatest good or the least harm for the greatest number of people.

11. VERACITY—truth telling or the duty to tell the truth.