Chapter 3

ETHICAL PRINCIPLES

The quality of mercy is not strain'd
It droppeth as the gentle rain from heaven
Upon the place beneath. It is twice blest:
It blesseth him that gives, and him that takes.

(William Shakespeare, *The Merchant of Venice*)

OBJECTIVES

After completing this chapter, the reader should be able to:

1. Discuss the principle of respect for autonomy in terms of patients' rights, informed consent, advocacy, and noncompliance.
2. Discuss the principle of beneficence as it relates to nursing practice.
3. Define the principle of nonmaleficence, and weigh actions in terms of harm and benefit.
4. Relate the principle of veracity to nursing practice.
5. Examine the principle of confidentiality in nursing practice, recognizing legal implications and reasonable limits to confidentiality.
6. Discuss the principle of justice as it relates to the delivery of health care goods and services.
7. Relate the principle of fidelity to nursing's promise to society.
8. Discuss situations in which there is a conflict between two or more ethical principles.

INTRODUCTION

Ethical issues are commonly examined in terms of a number of **ethical principles** Ethical principles are basic and obvious moral truths that guide deliberation and action. Major ethical theories utilize many of the same principles, though either the emphasis or meaning may be somewhat different in each. For example, respect for autonomy is a dominant principle in deontological theory but is less important in utilitarian theory. It is vital for nurses to understand ethical principles and be adept at applying them in a meaningful and consistent manner. (See Figure 3–1.) It is the authors' contention that consistent attention to principle is an important basis for ethical practice in nursing. This chapter examines the following ethical principles: respect for autonomy, beneficence, nonmaleficence, veracity, confidentiality, justice, and fidelity.

Respect for Persons

All of the principles discussed in this chapter presuppose that nurses have respect for the value and uniqueness of persons. Occasionally viewed as an ethical principle in its own right, **respect for persons** implies that 1 considers others to be worthy of high regard. Certainly, genuine regard and respect for others is the moving force behind all caring professions. Codes of nursing ethics explicitly state that respect for persons is a cornerstone of professional ethics. Discussion of the ethical principles in this chapter is based upon the belief that nurses value the principle of respect for persons.

RESPECT FOR AUTONOMY

As you would expect, the ethical principle of **respect for autonomy** denotes the ethical obligation to honor the autonomy of other persons. The word **autonomy** literally means self-governing. *Autonomy* denotes having

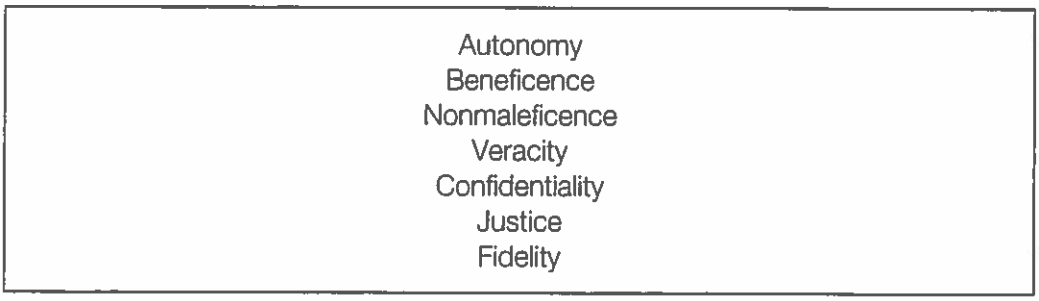

FIGURE 3–1 Principles of Ethics

the freedom to make choices about issues that affect one's life, free from lies, restraint, or coercion. Respect for autonomy is closely linked to the notion of respect for persons, and is an important principle in cultures where all individuals are considered unique and valuable members of society.

Implied in the concept of autonomy are four basic elements. First, the autonomous person is respected. It is logical that those choosing the nursing profession would inherently value and respect the unique humanness of others. This element is essential to assuring autonomy. Second, the autonomous person must be able to determine personal goals. These goals may be explicit and of a global nature, or may be less well defined. For example, the patient with an ankle injury may have a goal to return to athletic play within 2 weeks of the injury, or may simply wish to be pain free. In either case the patient develops personally chosen goals that are consistent with a particular lifestyle. Third, the autonomous person has the capacity to decide on a plan of action. The person must be able to understand the meaning of the choice to be made and also deliberate on the various options, while understanding the implications of possible outcomes. Imagine, for example, ordering from a restaurant menu written in a language you do not understand. You have the freedom and responsibility to make a choice, but cannot make a meaningful choice without an understanding of the various foods offered. When we believe that a patient is not able to comprehend the meaning of choices, goals, or outcomes, we say that the person is incompetent to make decisions, or lacks decision-making capacity. There are certain groups of patients that are generally thought of as unable to make informed choices. Children, fetuses, and those with mental impairments are among these groups. Fourth, the autonomous person has the freedom to act upon the choices. In situations where persons are capable of formulating goals, understanding various options, and making decisions, yet are not free to implement their plans, autonomy is either limited or absent. Autonomy may also be limited in situations where the means to accomplish autonomously devised plans do not exist. An example is seen in the case of the indigent person who has no health care insurance. This person may choose to have, for example, a pancreas transplant in lieu of insulin injections, but has no financial means to meet this goal. In order to assure autonomy, each of the four elements must be present to a reasonable degree.

A number of factors may threaten patient autonomy. The patient's role is a dependent one. The patient seeks health care assistance because of a real or perceived need and, as a result, can be perceived as dependent upon the health care provider. The role of the health care professional, on the other hand, is one of power. This power is based upon knowledge

ASK YOURSELF

Is the Patient Role a Dependent One?

- Describe a time when you or a family member experienced the role of hospitalized patient.
- How did you or your family member feel when interacting with members of the health care team, who were dressed, while you or your family member were in pajamas or a hospital gown or, worse yet, naked?
- Describe the degree to which you or your family member were able to maintain dignity and autonomy.

and authority and is inherent in the role. This complementary relationship, while a necessary one, can lead to violations of patient autonomy because the patient may not have the strength of will to exert his or her own autonomy.

Health care professionals are often insensitive to the ways in which the health care industry systematically dehumanizes and erodes the autonomy of consumers. Patients are forced to comply with rules that require them to be and act dependent. Immediately upon admission to a hospital, patients are disrobed, asked questions about personal and private matters, forced to relinquish money and belongings, and expected to remain in a bed, emphasizing the dependency of the patient role. We place patients in rooms with doors that are seldom closed and ask them to wear bed clothing. Workers who are strangers to patients freely enter and leave the patients' rooms, making privacy impossible. Regardless of patients' personal habits or knowledge of their own health care, they are forced to bathe at certain times, eat at certain times, and take medications at certain times, and are often prohibited from practicing self-care measures that may have been their habits for many years. Patients are expected to follow each plan that is made. Otherwise, they will be labeled difficult or *noncompliant.* For all the lip service given the importance of autonomy, health care professionals are often guilty of creating a climate of dependency for patients—of coercing otherwise autonomous, intelligent, and independent adults into essentially a very dependent role.

In cultures that do not regard all people as being of equal worth and in cultures that respect social structure above individual rights, autonomy is less important. Where slavery exists, where women are expected to be subservient to men, where minority races are not respected, or where children are exploited, the notion of autonomy is meaningless. Autonomy cannot thrive in a climate that does not allow for either the independent planning of personal goals or the privilege of examining and choosing options to meet goals.

Recognizing Violations of Patient Autonomy

Often, nurses and other health care workers fail to recognize subtle violations of patient autonomy. This especially occurs when nurses perceive choices to be self-evident. At least four factors are related to this failure. First, nurses may falsely assume that patients have the same values and goals as themselves. This state of mind compels some nurses to believe that the only reasonable course of action is the one that is consistent with their own values. This leads to faulty conclusions. For example, if an elderly person chooses to stay in her own home, even though to others she seems incapable of caring for herself, her choice might be viewed as unreasonable and might become grounds to believe the patient is incompetent to make decisions. In other words, "If you don't make the choices that seem correct to me, you must be incompetent to make decisions." In truth, the elderly person may recognize that life is drawing to a close and may want to remain in familiar surroundings, maintain dignity, remain independent, and prevent needless depletion of her life savings. The decision is based upon her thoughtful consideration of the consequences of staying home versus the consequences of living in a long-term care facility. There are some who would insist that she should be allowed to stay at home, even if she places herself at considerable danger, as long as she does not jeopardize the autonomy of others.

The second cause of failure to recognize subtle violations of patient autonomy lies in our failure to recognize that individuals' thought processes are different. Discounting a particular decision as incorrect may not take into consideration the fact that people process information in different ways. For example, there are those whose thought processes are very logical and methodical, and there are others who think in ways that are creative and free-flowing. It is particularly important to recognize these types of differences when several people are working together to come to a common decision. What is obvious to one will not be obvious to all—not necessarily because of a difference in values, knowledge base, or intellect, but because of different backgrounds and styles of thinking (Harrison & Bramson, 1982). This is an important consideration when collaborating with patients, families, and other professionals.

The third cause of failure to recognize subtle violations of patient autonomy lies in our assumptions about patients' knowledge bases. It is easy for us to forget that we have gained a specialized body of knowledge through nursing education and work experience. Knowledge about basic anatomy and physiology, disease process, the mechanism of action of drugs, and so forth is so ingrained in our minds that it is easy to presume everyone has at least some of the same type of knowledge. We often assume patients have more knowledge than is reasonable for them to have. Consequently, we may

discount or criticize patients' decisions, even though flaws lie in the patients' level of knowledge, rather than the appropriateness of decisions. Recall that an understanding of the choices, outcomes, and implications is inherently necessary for autonomous decision making. The nurse must accurately assess the patient's level of understanding in order to assure autonomy.

Most people accept the concept of autonomy, but few are prepared to accept total autonomy for every person in every situation. The ethical principle of respect for autonomy does not require you to respect all autonomous actions no matter how irrational the decision or horrible the results might be. Although you value the principle of respect for autonomy, you must simultaneously uphold responsibilities to yourself and to other people who could be harmed by a patient's choices. This can be a difficult distinction to make. To the extent that it is unreasonable accept the autonomous decisions and actions of all people in all circumstances, we are called to respect the principle of autonomy, rather than each autonomous action (Gillon, 1985).

The fourth cause of our failure to recognize subtle violations of patient autonomy lies in the unfortunate fact that in some instances the "work" of nursing becomes the major focus. This produces a climate of industrious habit. As we go about our work—doing procedures, giving medications, writing care plans, and trying to keep up a frantic pace—attentiveness to patient autonomy is sometimes neglected. In today's climate of advanced technology, fiscal uncertainty, staffing reductions, and bottom-line management, we should guard against focusing on work rather than caring.

Case Presentation

Noncompliance Versus Autonomy

Cora is a 45-year-old woman who looks years older than her stated age. She has very limited monthly income and no health insurance. Cora smokes two and one-half packs of cigarettes per day. She has severe COPD with constant dyspnea and frequent exacerbations. The nurse who sees her at a local free clinic is interested in at least preventing further problems, and speaks to Cora often about the importance of quitting smoking. The situation becomes very frustrating for all involved when Cora returns repeatedly for increasingly severe problems, having failed to quit smoking. Cora, of course, becomes labeled as noncompliant. During a particularly severe exacerbation, the nurse says to Cora, "You know you are committing suicide by continuing to smoke." Cora's reply is, "You don't understand. I live alone. I have no money, no friends, no family, and will never be able to work. I know the damage I'm doing, but smoking is the only pleasure I have in life."

Think About It

Do Nurses Coerce Patients?

- *In attempting to persuade Cora to stop smoking, to what degree is the nurse violating Cora's right to autonomy?*
- *Does Cora have the right to choose to continue smoking?*
- *If rights and responsibilities are correlative, how should the clinic respond to Cora's continuing to smoke? Would you suggest that the clinic continue to serve Cora, even though she is not following the plan of care?*
- *To what degree is coercion employed in situations such as Cora's? Is coercion an appropriate strategy?*
- *What would you do if you were the nurse?*

Autonomy for patients is more frequently discussed in terms of larger issues, such as informed consent, paternalism, advocacy, compliance, and self-determination. Let us review this principle as related to these and other recurrent themes.

Informed Consent

Informed consent is a term used to describe the process by which competent patients give voluntary consent for medical or surgical treatments or biomedical research after receiving disclosure about potential risks and benefits. Informed consent is the practical application of the principle of respect for autonomy. It demonstrates legal protection of a patient's right to personal autonomy in regard to specific treatments and procedures. The concept of informed consent is one that has come to mean that patients are given the opportunity to autonomously choose a course of action in regard to plans for medical care. This is usually discussed in relation to surgery, complex medical procedures, and research.

Our contemporary practice of informed consent is a direct outcome of past research atrocities. Although research focusing on the human body, illness, and injury has its roots in the ancient world, it was not until after World War II that organizations and governments began to create policies to protect human subjects of medical research. World War II created a perfect storm in which ethical research violations seemed to occur on a large scale in many countries. Voluntary and non-voluntary medical experiments to improve medical practice included infecting participants with pathogens; inflicting mortal wounds; and exposing subjects to

high-altitude, freezing conditions, radiation, and biological and chemical agents (Harris, 1999; United States Holocaust Memorial Museum, 2010; Weindling, 1996). Highly publicized accounts of atrocious human rights violations spurred the development of policies that now affect every aspect of health care delivery.

When Nazi physicians were charged with war crimes, there were no established guidelines for ethical conduct in research. Therefore, in the course of the trial, the judges developed a set of 10 ethics guidelines by which to compare the conduct of the Nazi physicians (Nuremberg Military Tribunal, October 1946–April 1949; Shuster, 1997; Weyers, 2007). The first and most prominent guideline established that research must be voluntary, as follows:

> The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. (Nuremberg Military Tribunal, October 1946–April 1949, pp. 181–182)

Following the Nuremberg trials, international government and professional bodies began to institute policies and guidelines for informed consent that spilled over from research into medical and surgical care. These policies include many ethical and legal requirements. Nurses must understand the process and the legal requirements for each step. More specific details about informed consent are found in Chapters 11 and 12.

Paternalism

Paternalism is a gender-biased term that literally means acting in a *fatherly* manner. The traditional view of paternal actions includes such role behaviors as leadership, benevolent decision making, protection, and

discipline. As commonly used in nursing, however, the term *paternalism* carries negative connotations, particularly related to implied dominant male versus submissive female roles. For example, before the age of informed consent, physicians advocated a "fatherly" role that allowed them to make decisions regarding the best form of treatment. An early leader in medical ethics, Dr. Thomas Percival, advocated this fatherly and authoritative role when he wrote, "Physicians should study, also, in their deportment, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence (Percival, 1803, p. 27). Apparently not an advocate of informed consent, he also advocated withholding information from the patient when he wrote, "As misapprehension may magnify real evils or create imaginary ones, no discussion concerning the nature of the case should be entered into before patients. . . ." (p. 29). As viewed today, this gender-biased concept of paternalism has negative connotations.

The term *paternalism* generally evokes negative sentiments among nurses. This is due in part to recognition that in the past the autonomy of patients was frequently violated in the name of beneficence. Professionals sometimes make the dangerous assumptions that they are uniquely qualified to make health care decisions by virtue of their professional knowledge and, further, that professional knowledge is the only knowledge needed to make decisions for patients. This kind of thinking allows us to ignore multiple factors that might be unrelated to physical outcomes, yet affect the whole person. These factors include, among others, economic considerations, lifestyle, values, role, culture, and spiritual beliefs. In making decisions, all possible factors must be taken into consideration. This dictates that the patient must be autonomously engaged in the decision-making process.

It is interesting to compare discussions of the concept of paternalism in both the nursing and medical literature. Nursing literature generally describes paternalism in a negative way. Nurses often think of paternalism as behavior that precludes autonomy. Medical literature, as noted previously in the writings of Thomas Percival, discusses paternalism as a benevolent quality. The following passage that supports paternalism illustrates this point (note the pronoun "she"):

> In its strong version, the principle of paternalism justifies restricting someone's autonomy if by doing so we can benefit her. In such a case, our concern is not only with preventing the person from harming herself, but also with promoting her good in a positive way. The principle might be appealed to even in cases in which our actions go against the other's known wishes. (Munson, 1992, p. 43)

Advocacy

Advocacy is the act of speaking or pleading on another's behalf. Patient advocacy is central to nursing and is implicitly or explicitly included in nursing codes of ethics. It honors patients' autonomy. The act of advocacy in nursing is generally an informal, implicit function of the nurse-patient relationship. The goal of nursing advocacy is to ensure the welfare of the patient. Differing from paternalism, advocacy seeks goals that are determined by the patient or that the nurse believes the patient would have chosen. Virginia Henderson was one of the first nursing scholars to describe the advocacy role of nurses. She described advocacy as nurses helping patients do what they would ordinarily do for themselves when they lack the strength, will, or knowledge to care for themselves (Henderson, 1966).

Nursing advocacy occurs in many different types of situations. The nurse who communicates the patient's wishes in a staff meeting and the one who supports the patient in decision making are both advocates. Nurses can be advocates when in the presence of patients, when patients are not present to express their own wishes, or when patients have diminished decision-making capacity.

Advocacy is especially appropriate when a patient has diminished decision-making capacity or is unable to communicate. The nurse is often in the best position to know the patient's wishes. As advocates, we choose for the patient what we believe the patient would have chosen for his-or herself, if that were possible. For example, we assume that a person would choose to be protected from injury. Within that context, when we believe an elderly, agitated patient is incompetent, we might employ means to eliminate falls or wandering. This type of advocacy should not be evoked simply because the nurse senses a risk of harm. Ironically, Virginia Henderson, the well-known nursing leader who first defined nursing advocacy, recounts her experience as a hospitalized patient:

> I was in the room with another patient, and I couldn't stand being in bed any longer, and I would sit in a chair. This nurse came in and saw me sitting in the chair, and she said "Ms. Henderson if you keep doing that, we are going to have to tie you down"... I thought, You just try it.... (Goldsmith, 1992, p. 4)

Even though Ms. Henderson was 94 years old at the time of her hospitalization, she was certainly competent to make decisions for herself. Patients who are competent must be allowed to act autonomously—even if the choices can be predicted to cause them harm or render them incompetent. The exception can be made that even competent persons cannot

be allowed to act in a way that would cause harm to others. Advocacy combines genuine concern for the patient with a well-founded belief that the patient is unable to make autonomous decisions.

ASK YOURSELF

Who Should Make Decisions?

- How do you feel when someone else makes a decision about you without your input?
- Since nurses and doctors know more about the science of health care, when, if ever, is it appropriate for them to make decisions about the health care regimen without participation of the patient?

Especially when patients are unable to communicate or have diminished decision-making capacity, there can be a thin line between advocacy and paternalism (Zomorodi & Foley, 2009). We suggest that the difference lies in the locus of power. Paternalism places power in the hands of the person who is making the decision for the patient. It implies that the decision maker knows what is best. With true advocacy, the patient retains the power. Advocacy expresses respect for the patient's autonomy because it aims to act according to the patient's own values. Zomorodi and Foley (2009) warn that nurses may not know the patient's wishes and may not have access to family members who can act as surrogates. In this situation, it is possible for nurses to act in what they think are the best interests of the patient, but they can unwittingly move toward medical paternalism. Therefore, nurses must constantly evaluate their actions to enhance the advocacy role and avoid paternalism.

Noncompliance

The term **noncompliance** is generally thought of as denoting an unwillingness of the patient to participate in health care activities. This commonly entails lack of participation in a regimen that has been planned by the health care professional but must be carried out by the patient. Examples of such activities include taking medication as scheduled, maintaining a therapeutic or weight-loss diet, exercising regularly, and quitting smoking. Use of the term *noncompliance* is just as likely to represent failure of the nurse as it represents failure of the patient. Discussions about noncompliance and care of the noncompliant patient center around two basic factors. First, the autonomous participation of the patient in the health care plan is essential to success. When patients are fully aware of the choices in health care therapies

and the consequences of non-treatment, and are encouraged to make health care decisions, they are more likely to assume ownership of them and, as a result, to participate in their own care. Often nurses formulate plans of care that are consistent with a scientific base of knowledge but seem unreasonable to the patient. The nurse is remiss if the patient is not an autonomous participant in the formulation of the plan. Second, nurses and other health care professionals must assess patients' abilities to follow plans of care. Patients may be unable to comply with plans for a variety of reasons, including lack of resources, lack of knowledge, lack of support from family members, psychological factors, and cultural beliefs that are not consistent with proposed plans of care. An example of patients' inability to comply with a plan of care is seen every day in physicians' offices and emergency departments. Often patients are given prescriptions for medications that are prohibitively expensive. When they return with the same symptoms, not having taken the prescribed medication, they are invariably labeled as noncompliant. The problem is not one of compliance, but rather the health care professionals' negligence in assessing their patients' ability to follow a plan of care.

What are we to do when patients are well informed and apparently able to follow plans of care, yet do not? One hears stories of physicians who dismiss patients who do not comply with instructions—smoking cessation, for example. In a climate of limited resources, this is a question worthy of contemplation. Codes of ethics for nurses universally support respect for individuals and individual choice, and are not restricted by considerations of social or economic status (American Nurses Association [ANA], 2001; International Council of Nurses [ICN], 2006; Canadian Nurses Association [CNA], 2008). Further, the nurse must not be affected by patients' individual differences in backgrounds, customs, attitudes, and beliefs. Because health care practices are an integral part of patients' backgrounds, customs, and beliefs, refusal to participate in a plan of care, regardless of the outcome, is the prerogative of the patient and must not affect the care given by the nurse. Ultimately, choices about health care practices belong to patients. If allowed to choose, patients should not be labeled in a negative way when nurses do not agree with their choices. It is not appropriate for professionals who express the belief that all competent patients have the right to autonomous choice to make value judgments about the choices made, and subsequently label patients as noncompliant.

BENEFICENCE

The principle of **beneficence** means to do good. It requires nurses to act in ways that benefit patients. Beneficent acts are morally and legally demanded by the professional role (Beauchamp & Walters, 2007). The

objective of beneficence provides nursing's context and justification. It lays the groundwork for the trust that society places in the nursing profession, and the trust that individuals place in particular nurses or health care agencies. Perhaps this principle seems straightforward, but it is actually very complex. As we think about beneficence, certain questions arise: How do we define beneficence—what is *good?* Should we determine what is good by subjective, or by objective, means? When people disagree about what is good, whose opinion counts? Is beneficence an absolute obligation and, if so, how far does our obligation extend? Does the trend toward unbridled patient autonomy outweigh obligations of beneficence? Veatch (2002) asks whether the goal is really to promote the total well-being of the patient or to promote only the *medical* well-being of the patient. We must keep these questions in mind as we practice.

The ethical principle of beneficence has three major components: do or promote good, prevent harm, and remove evil or harm. (See Figure 3–2.) Beneficence requires that we do or promote good (Beauchamp & Childress, 2008). Even with the recognition that *good* might be defined in a number of ways, it seems safe to assume that the intention of nurses in general is to do good. Questions arise when those involved in a situation cannot decide what is *good.* For example, consider the case of a patient who is in the process of a lingering, painful, terminal illness. There are those who believe that life is sacred and should be preserved at all costs. Others believe that a natural and peaceful death is preferable to an extended life of pain and dependence. The definition of *good* in any particular case will determine, at least in part, the action that is to be taken.

The principle of beneficence also requires us to prevent or remove harm (Beauchamp & Childress, 2008). In fact, some believe that doing no harm, and preventing or removing harm, is more imperative than doing good. All codes of nursing ethics require us to prevent or remove harm. For example, the International Council of Nurses (ICN) *Code of Ethics for Nurses* (2006) says, "The nurse takes appropriate action to safeguard individuals, families and communities when their care is endangered by a co-worker or any other person." Similarly, the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (2008) says, "Nurses

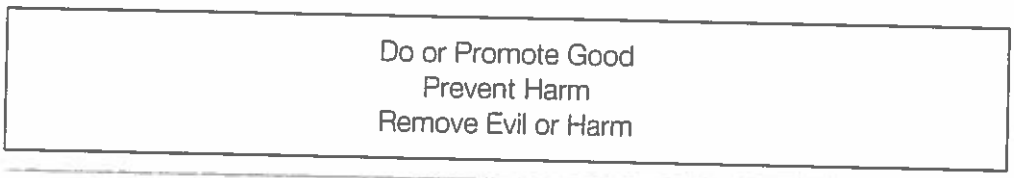

FIGURE 3–2 Beneficence

question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same" (p. 9).

Likewise, the American Nurses Association (ANA) *Code of Ethics for Nurses* (2001) is very clear about the nurse's responsibility in these situations: "As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy." In regard to removing harm, the ANA *Code of Ethics for Nurses* (2001) is very specific. Steps include the following: expressing concern to the person carrying out the questionable practice, reporting the practice to the appropriate authority within the institution, and if not corrected, reporting the problem to other appropriate authorities, such as practice committees of the pertinent professional organizations or licensing boards.

NONMALEFICENCE

The principle of **nonmaleficence** is related to beneficence. Whereas beneficence requires us to prevent or remove harm, nonmaleficence requires us to avoid actually causing harm. Included in this principle are deliberate harm, risk of harm, and harm that occurs during the performance of beneficial acts. Most ethicists today tend toward the Hippocratic tradition that says to first do no harm (the principle of nonmaleficence), placing this principle above all others. It is obvious that we must not commit acts that cause deliberate harm. This principle prohibits, for example, experimental research when it is fairly certain that participants will be harmed, and the performance of unnecessary procedures for economic gain or solely as a learning experience.

Nonmaleficence also means avoiding harm as a consequence of doing good. In such cases, the harm must be weighed against the expected benefit. For example, sticking a child with a needle for the purpose of causing pain is always bad—there is no benefit. Giving an immunization, on the other hand, while causing similar pain, results in the benefit of protecting the child from serious disease. The harm caused by the pain of the injection is easily outweighed by the benefit of the vaccine. In day-to-day practice, we encounter many situations in which the distinction is less clear, either because the harm caused may appear to be equal to the benefit gained, because the outcome of a particular therapy cannot be assured, or as a result of conflicting beliefs and values. For example, consider analgesia for patients with painful terminal illness. Narcotic analgesia may be the only type of medication that will relieve very severe pain. This medication, however, may result in dependence and

can hasten death when given in amounts required to relieve pain. Cammon and Hackshaw (2000) offer another common example. Orders for patients to have nothing by mouth before procedures and tests are common practice, unquestioned by most nurses. The authors cite examples in which elderly patients were denied food for up to 6 days as tests and procedures were completed. The consequences of starvation in the elderly are unquestionable,

Case Presentation

Beneficence Versus Nonmaleficence

A middle-aged nurse recounts an incident that she believes relates to the principle of nonmaleficence. As a senior nursing student she was responsible for the care of a man who had a shotgun wound to his abdomen. Surgery had been performed, and the surgeon was unable to adequately repair the damage. The man was not expected to survive the day. He was, however, awake and strong, though somewhat confused. He had a fever of 107° Fahrenheit. He was receiving intravenous fluids and had continuous nasogastric suction. The man begged for cold water to drink. The physician ordered nothing by mouth in the belief that electrolytes would be lost through the nasogastric suction if water were introduced into the stomach. The student had been taught to follow the physician's orders. She repeatedly denied the man water to drink. She worked diligently—giving iced alcohol baths, taking vital signs, monitoring the intravenous fluids, and being industrious. He begged for water. She followed orders perfectly. After six terrible hours she turned to find the man quickly drinking the water from one of his ice bags. She left the room, stood in the hallway, and cried. She felt she had failed to do her job. As a result of the gunshot wound, the man died the next morning. Today her view of the situation is different.

Think About It

Weighing Harm Against Benefit

- *Was this patient harmed? Discuss your answer.*
- *What was the benefit of the nothing-by-mouth order?*
- *Discuss whether the harm of thirst or the benefit of maintaining nothing by mouth should take precedence.*
- *What other ethical principles are relevant?*
- *Why did the student experience such extreme distress?*

yet the practice of following NPO orders for long periods of time is seldom questioned. As nurses, we must be alert to situations such as these in which harm may outweigh benefit, taking into account our own values and those of patients.

The Case Presentation on the previous page illustrates the difficulty encountered when attempting to honor the principles of beneficence and nonmaleficence.

VERACITY

The term **veracity** relates to the practice of telling the truth. Truthfulness is widely accepted as a universal virtue. Most of us were taught as children to always tell the truth. Philosophers, in general, favor openness and honesty. The philosophers most frequently cited in nursing literature, Immanuel Kant and John Stuart Mill, agree in favor of truth telling. Nursing literature promotes honesty as a virtue and truth telling as an important function of nurses. However, there are some differences in perspective among health care professionals. Bioethicists disagree on the absolute necessity of truth telling in all instances.

We can support nurses' practice of telling the truth in many ways. Truth telling engenders respect, open communication, trust, and shared responsibility. It is promoted in all professional codes of nursing ethics.

A very general interpretation of the ideas of the philosopher Martin Buber (1965) suggests that true communication between people can take place only when there are no barriers between them. Lying or deception creates a barrier between people and prohibits both meaningful communication and the building of relationships. Recognizing that communication is the cornerstone of the nurse-patient relationship, an argument can be made that nurses must be truthful in order to communicate effectively with patients.

Violating the principle of veracity shows a lack of respect. Telling lies, or avoiding disclosure, implies that the nurse or other person involved assumes prominence over the patient or, at the very least, disrespects the patient's autonomy. Jameton (1984) suggests that manipulating information for the purpose of controlling others is like using coercion to control them. In essence, this keeps them from participating in decisions on an equal basis.

Jameton (1984) also suggests that deceiving others may constitute an unnecessary assumption of responsibility. When unfortunate consequences occur, the one responsible for the deception can also be assumed to be responsible for the consequences. On the other hand, when bad consequences occur after we have reported the truth, we can attribute responsibility to unfortunate circumstances.

Truth telling engenders trust. We can make the argument that truth telling is imperative to assure that patients continue to trust nurses and other health care professionals. It is by virtue of the trust in these relationships that patients are willing to suspend some measure of autonomy and seek help in meeting health care needs. Without this trust the nurse-patient relationship would be destroyed.

ASK YOURSELF

Is Truth Telling Always Beneficent?

- What situational variables influence how you feel about giving placebos?
- If your goal is to be beneficent and if the patient would benefit from a placebo, is deception justifiable if it will help the patient?
- What principles are in conflict when giving placebos?

Veracity has been described as desirable by the American Hospital Association (AHA) in the *Statement on a Patient's Bill of Rights* (1973, rev. 1992). According to this document, patients have the right to obtain complete, current information concerning diagnosis, treatment, and prognosis in terms they can be reasonably expected to understand. Though this position relates specifically to physicians' responsibility of disclosure, there are implications for nursing as well. As patient advocates, nurses are responsible for assuring that patients' rights are honored.

As with other principles, there is a dramatic discrepancy between nursing and medical literature in regard to veracity. Recognizing that nearly all health care is an interdisciplinary effort, and that disclosure of information to patients involves both nurses and physicians, it is important for us to understand the medical perspective.

Physicians often make the claim that patients do not want bad news, and that truthful information has the potential to harm them. In the name of beneficence, some physicians proceed with either nondisclosure or outright lies. Lipkin (1991) argues that physicians should sometimes deceive their patients or withhold information from them. It is his view that patients do not have sufficient information about how their bodies function to interpret medical information accurately, and sometimes they do not want to know the truth about their illness. Joseph Ellin (1991) discusses special considerations that have been posed by the medical profession in relation

to truth telling. He suggests that it does not seem beneficent to adopt an ethic of absolute veracity in which it is an obligation to cause avoidable anguish to someone who is already ill, especially when hope and positive outlook may promote healing and help prolong life. He writes, "One could hope to avoid this dilemma by holding that the duty of veracity, though not absolute, is to be given very great weight, and may be overridden only in the gravest cases..." (p. 82). Ellin draws a distinction between lying and deception: lying is the purposeful telling of untruths, whereas deception is usually accomplished through nondisclosure. He argues that there is an absolute duty to avoid lying to patients; however, there is no duty not to deceive. Examples he gives include withholding information about a poor prognosis or giving placebo medication. Consider the following situation: A mother of four is admitted to the emergency department after an automobile accident in which two of her children are killed. Recognizing that she is in very serious condition, it would be appropriate, according to Ellin, to avoid telling her of the death of her children. If, however, she asks about their condition, she must be told the truth.

ASK YOURSELF

Is the Truth Sometimes Harmful?

- Do you think it is acceptable to deceive a patient in order to prevent unnecessary suffering?
- How would you feel if you were a patient and the health care team and your family conspired to deceive you—if, for example, you were ill and you had a bleak prognosis?
- Do you think it is acceptable to tell an Alzheimer's patient "little white lies" in order to decrease agitation?

Bok (1991) examines the practice of physicians deceiving patients in the name of beneficence. Although many would classify deceiving patients as paternalism, Bok writes that lying to patients has historically been seen as an excusable act. "Some would argue that doctors, and only doctors, should be granted the right to manipulate the truth in ways so undesirable for politicians, lawyers, and others" (p. 75). In fact, truth telling has never been a principle that was given consideration in physicians' literature. Veracity is absent from virtually all medical oaths, codes, and prayers. Even the Hippocratic Oath makes no mention of truthfulness. The 1847 version of the American Medical Association Code of Ethics endorses some forms of deception by stating that the physician has a sacred duty to avoid "all things which have a tendency to discourage the patient and to depress his spirits" (Bok, 1994, p. 1683).

Nursing and medicine view veracity from two different perspectives. I is clear that physicians have traditionally seen disclosure or nondisclosure t be a facet of care within their control that can have implications for patien welfare. Physicians often consider withholding bad news to be a beneficen act if they think disclosing the information will harm the patient. Nursing on the other hand, upholds veracity as supporting individual rights, respect for persons, and the principle of respect for autonomy. To collaborate successfully, however, one must recognize the viewpoints of others. Chapter 4 discusses methods of making decisions about ethical problems when there are differences of perspective among those involved.

Confidentiality

The terms *confidentiality* and *privacy* are interrelated. **Privacy** refers to the right of an individual to control the personal information or secrets that are disclosed to others. Privacy is a fundamental right of individuals (O'Keefe, 2001). The ethical principle of **confidentiality** demands nondisclosure of private or secret information about another person with which one is entrusted. That is, confidentiality requires that one maintain the privacy of another. When the nurse learns private information about a patient, the nurse must keep that information confidential, sharing only that information necessary to provide patient care (ANA, 2001). Codes and oaths of nursing and medicine dating back many centuries support the principle of confidentiality. Nursing codes of ethics require that we maintain the confidentiality of patient information. According to the ICN *Code of Ethics for Nurses* (2006), "The nurse holds in confidence personal information and uses judgement in sharing this information." Similarly, the ANA *Code of Ethics for Nurses* (2001) and the CNA *Code of Ethics for Registered Nurses* (2008) direct nurses to maintain confidentiality. Confidentiality is the only facet of patient care mentioned in the Nightingale Pledge. This oath has been recited for decades by graduating nurses: "I will do all in my power to elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my profession." Physicians do not escape the promise of confidentiality. The Hippocratic Oath is very clear: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." Although there are compelling arguments in favor of maintaining confidentiality, there is disagreement about the absolute requirement of confidentiality in all situations.

The ability to maintain privacy in one's life is an expression of autonomy. The capacity to choose what others know about us, particularly intimate personal details, is important because it enables us to maintain dignity and preserve a measure of control over our own lives. Markus and Lockwood discuss the importance of privacy:

> Privacy is thus a value closely related to, and perhaps ultimately grounded on, the value of personal autonomy. To take this value of privacy seriously is to subscribe to a number of familiar precepts. It means that we should be reluctant to pry, that we should respect personal confidences, and that when we enter into relationships with others that render us privy to sensitive or intimate personal information, we should be [careful] about passing this information on, even in the absence of any specific request not to do so. (1991, p. 349)

Thus, maintaining confidentiality of patients is an expression of respect for persons and, in many ways, is essential to the nurse-patient relationship. Consider the following Case Presentation.

There are at least two basic ethical arguments in favor of maintaining confidentiality. The first of these is the individual's right to control personal information and protect privacy. The second argument is one of utility.

This right to privacy flows from respect for persons and their autonomy. On one level, patients have the right to expect that personal and private information will not be shared unnecessarily among health care providers. Patient information is not an appropriate topic for elevator or dinner conversation. It is most likely that violations of this nature were what authors

Case Presentation

Making the Best Choice

Lora is a 17-year-old cheerleader. She comes to the local family planning clinic requesting birth control pills. Lora is a very attractive, neat, and pleasant patient. In the process of completing the initial physical examination, the nurse practitioner finds evidence of physical abuse, including a recent traumatic perforated eardrum. Lora hesitantly and tearfully admits that her biological father slapped her across her left ear prior to her coming to the clinic. She reports that she recently moved into his home after living most of her life with her mother and stepfather. She tearfully reports that her stepfather was sexually abusive to her and that she wishes to remain with her biological father. She says that she can tolerate being slapped around occasionally, and she does not want to get her biological father in trouble or be forced to move back to her stepfather's home. State law requires that the nurse report any suspicion of child abuse. Both codes of ethics and federal law require that the nurse maintain confidentiality.

Think About It

To Tell or Not to Tell

- *What are the principles involved?*
- *Does the nurse's obligation to report the incident of child abuse supersede the obligation to maintain confidentiality—particularly considering that the patient requested confidentiality? What if Lora were 14 years old?*
- *What are the options for the nurse?*
- *What are the possible outcomes of the different options?*
- *Does Lora's autonomy outweigh the nurse's responsibility to report the abusive situation?*

had in mind when writing early creeds and oaths that promise confidentiality. Nurses and other professionals often casually discuss private patient matters. On another level, nurses must keep in mind the number of people who have legitimate access to patient records. In a hospital situation, patient charts are accessible to many personnel. Nurses, physicians, dieticians, respiratory therapists, utilization review staff, financial officers, students, secretaries, physical therapists, and others have legitimate reason to view patient records. Information of a sensitive and private nature that the patient intends for the nurse alone can become widely known in a large health care facility. Care must be taken in choosing information to be recorded in patients' charts. Special care must be taken to avoid inadvertent breaches of confidentiality (Erlen, 1998), including those involved with electronic records (Muldoon, 1996). It is important for nurses to be aware of the many threats to patient confidentiality.

Confidentiality is particularly important when revelation of intimate and sensitive information has the potential to harm the patient. Harm can take various forms, such as embarrassment, ridicule, discrimination, deprivation of rights, physical or emotional harm, and loss of roles or relationships. Consider the plight of many AIDS victims whose diagnoses have become public knowledge. Confidentiality is also particularly important when dealing with vulnerable populations (Winston, 1988).

The second argument is one of utility. If patients suspect that health care providers reveal sensitive and personal information indiscriminately, they may be reluctant to seek care. Government policy makers recognize this problem. Because of the intimate and private nature of reproductive health issues, confidentiality of those seeking family planning services, for example, is mandated. Those caring for AIDS patients also recognize the need to maintain confidentiality. According to Winston (1988), many who

work with AIDS patients find such arguments particularly compelling, believing that disclosure of patients' antibody status or a diagnosis of AIDS would have a "chilling effect," discouraging those in high-risk groups from seeking care. There are other diagnoses, such as mental illness, alcoholism, and drug addiction, that, if revealed, could lead to public scorn and subsequently discourage others from seeking care.

Limits of Confidentiality

Should the principle of confidentiality be honored in all instances? There are arguments that favor questioning the absolute obligation of confidentiality in certain situations. These arguments include theories related to the principles of harm and vulnerability (Winston, 1988). The harm principle can be applied when the nurse or other professional recognizes that maintaining confidentiality will result in preventable wrongful harm to innocent others. Mandatory premarital testing for syphilis, for example, is intended to prevent the spread of a serious communicable disease to innocent babies and spouses. In this instance, society chooses to override the privacy of the individual to protect the health of the innocent. Though directing nurses to maintain confidentiality, the ANA *Code of Ethics for Nurses* (2001) recognizes that duties of confidentiality are not absolute and may need to be modified to protect the patient, other innocent people, and, in cases of mandatory disclosure, for public safety.

In rare instances, case law supports the harm principle. In July of 1976, the California Supreme Court ruled that a psychologist, Dr. Lawrence Moore; his superior, Dr. Harvey Powelson; and the agency for which they worked were liable in the wrongful death of Tatiana Tarasoff. Prosenjit Poddar killed Tatiana Tarasoff in October of 1969. According to Tatiana's parents, 2 months earlier Poddar had confided his intention to kill Tatiana to his psychologist, Dr. Moore. Though Dr. Moore initially tried to have his patient involuntarily committed, Dr. Powelson intervened and allowed Poddar to return home. Neither Tatiana nor her parents were informed of the patient's threats. The court found that the defendants were responsible for the wrongful death of Tatiana because they knew in advance of the patient's intentions. The obligation to protect the innocent third party superseded the obligation to maintain confidentiality. According to the majority opinion in this case, the duty to warn arises from a special relation between the patient and the psychologist that imposes a duty to control the patient's conduct (Tobriner, 1991).

Foreseeability is an important consideration in situations in which confidentiality conflicts with the duty to warn. The nurse or other health care professional should be able to reasonably foresee harm or injury to an innocent other in order to violate the principle of confidentiality in favor of a duty to

warn. This consideration precludes blanket disclosure of private information that might predict harm to others. The Tarasoff case exemplifies reasonable application of the harm principle. Subsequent court cases support the decision in the Tarasoff case. Courts have found that privacy is not absolute and is subordinate to the state's fundamental right to enact laws that promote public health.

The harm principle is strengthened when one considers the vulnerability of the innocent (Haggarty, 2000). The duty to protect others from harm is stronger when the third party is dependent on others or is in some way especially vulnerable. This duty is called the vulnerability principle. Vulnerability implies risk or susceptibility to harm when vulnerable individuals have a relative inability to protect themselves (Winston, 1988). For example, nurses have an absolute duty to report child abuse. Because children are dependent and vulnerable, they are at greater risk of harm. Coupling of the harm principle with the vulnerability principle produces a rather strong argument for abandoning the principle of confidentiality in certain instances.

Actions that are considered ethical are not always found to be legal. Though there is an ethical basis for subsuming the principle of confidentiality in special circumstances, and there is some legal precedent for doing so, there is legal risk to disclosing sensitive information. There is dynamic tension between the patient's right to confidentiality and the duty to warn innocent others. Nurses need to recognize that careful consideration of the ethical implications of actions will not always be supported in bureaucratic and legal systems.

U.S. federal legislation made the delicate balance between ethical principles more complex when confidentiality of patient information

Think About It

Can Nurses Violate Confidentiality?

- *How do you think confidentiality and the harm and vulnerability principles can be reconciled?*
- *How would you feel if a relative contracted HIV from a source who public health officials knew was infected, and had reason to believe would infect your relative, but neglected to warn?*
- *How would you feel if you were HIV infected and your health care provider violated your right to confidentiality?*

became a legal mandate. In 1996, Congress enacted Public Health Law 104–199, the Health Insurance Portability and Accountability Act (HIPAA). In response to public concerns related to a more mobile society, the need for health insurance, and the rising administrative costs of health care (Erlen, 2004), federal legislators set out to create and protect a universal databank of medical information using standardized coding systems (Deshefy-Longhi, Dixon, Olson, & Grey, 2004). Because of a growing number of criminal violations of electronic records, Congress inserted a provision that enjoined the U.S. Department of Health and Human Services to create medical privacy rules. Even though the original intent of HIPAA was never realized, the privacy guidelines went into effect in 2003 (Department of Health and Human Services [HIPAA], 2002, rev. 2003). Known widely as HIPAA, these privacy rules made confidentiality a legal requirement. Whereas other ethical principles do not carry the weight of law, *per se,* confidentiality stands alone. Today, a breach of confidentiality may result in criminal conviction or other penalties.

JUSTICE

Justice is the ethical principle that relates to fair, equitable, and appropriate treatment in light of what is due or owed to persons, recognizing that giving things to some will deny receipt to others who might otherwise have received those things. Within the context of health care ethics, the most relevant application of the principle focuses on distribution of goods and services. This application is called **distributive justice**. Unfortunately, there is a finite supply of goods and services, and it is impossible for all people to have everything they might want or need. One of the primary purposes of governing systems is to formulate and enforce policies that deal with fair and equitable distribution of scarce resources.

Decisions about distributive justice are made on a variety of levels. The government is responsible for deciding policy about broad public health access issues, such as children's immunization and Medicare for the elderly. Hospitals and other organizations formulate policy on an institutional level and deal with issues such as how decisions will be made concerning who will occupy intensive care beds and which types of patients will be accepted in emergency rooms. Nurses and other health care providers frequently make decisions of distributive justice on an individual basis. For example, having assessed the needs of patients, nurses decide how best to allocate their time (a scarce resource).

There are three basic areas of health care that are relevant to questions of distributive justice. First, what percentage of our resources is it reasonable to spend on health care? Second, recognizing that health care resources are limited, which aspects of health care should receive the most resources? Third, which patients should have access to the limited health care staff, equipment, and so forth (Jameton, 1984)?

In making decisions of distributive justice, one must ask the question, "Who is entitled to these goods or services?" Philosophers have suggested a number of different ways to choose among people. Figure 3–3 lists some of the ways that people have historically made these types of decisions.

There are those who believe that all should receive equally regardless of need. On the surface, nationalized health care systems would seem to meet this criterion, since all citizens are eligible for the same services. However, because some citizens would necessarily require more health care services than others, nationalized systems also meet the criterion of need. The German philosopher Friedrich Nietzsche had a different perspective. He believed that there are superior individuals, and that society's goal should be to enhance these "supermen." For Nietzsche, the choice of distribution was a clear one—to each according to his present or future social contribution (Durant, 1926). To each according to that person's rights indicates a libertarian viewpoint, and to each as he or she would wish to be treated is a reflection of the Golden Rule. The idea that each should receive according to effort is a common belief in our culture and indicates the traditional "work ethic." Entitlement programs in the United States generally award benefits based upon a combination of need and the greatest good that can be accomplished for the greatest number of people. Chapter 15 discusses the application of the principle of distributive justice in greater detail.

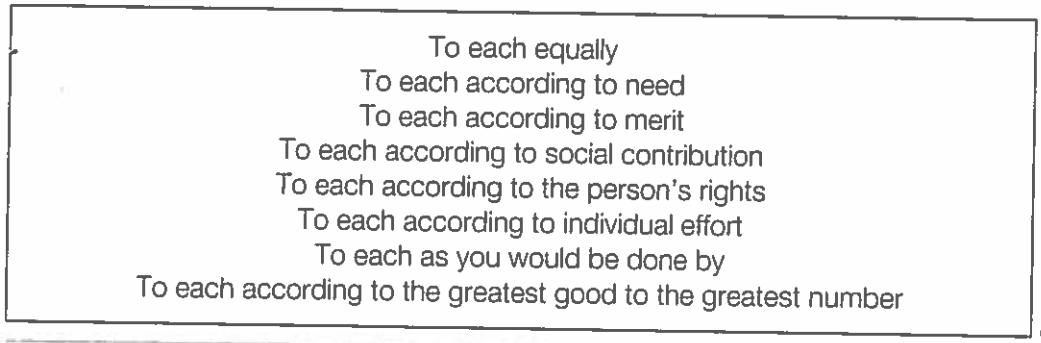

FIGURE 3–3 Distributive Justice

Case Presentation

The Case of H1N1

The H1N1 influenza pandemic of 2009–2010 provides a dramatic example of distributive justice in health care. In April 2009 a new strain of an old virus emerged. Venters for Disease Control and Prevention (CDC) officials were required to distribute resources during this period of crisis and to make morally pertinent decisions about how to ration the scarce vaccine. Some have criticized the CDC's 2009–2010 response to H1N1. When discussing the ethics of distributive justice, it is important to examine all factors. We will review two previous outbreaks and try to understand their impact on the 2009 public health response.

In 1918, an estimated 500 million people worldwide were infected with the "swine flu" virus. The strain of the disease was exceptionally severe, with total deaths estimated to be 50 million (Taubenberger & Morens, 2006). The virulent, highly contagious virus produced three pandemic waves in rapid succession. Before the pandemic receded, one-third of the world's population had been infected.

In 1976, U.S. public health officials identified a handful of swine flu cases. With the 1918 pandemic hovering in the background and a consensus that a vaccine came too late for a 1956 Hong Kong flu pandemic, CDC officials called for rapid mass immunizations. The first shots were given on October 1, 1976. Within 2 months it became clear that those who were vaccinated had an 11 times greater chance of developing Guillain-Barré Syndrome. By the time the mass immunizations were suspended in December 1976, 40 million Americans had already received the vaccine. The predicted pandemic never materialized and those who were infected experienced low morbidity and almost no mortality. The vaccine appeared to have been more dangerous than the disease. The 1976 swine flu vaccine program was "overwhelmingly recalled as a true 'fiasco,' a 'disaster,' and a 'tragedy,'" (Neustadt & Fineberg, 2005).

When the first case of H1N1 emerged on April 15, 2009, the CDC quickly became involved. The CDC initially referred to the new influenza as "swine origin influenza" virus. Officials quickly moved forward with awareness that the potential death toll could mimic that of the 1918 pandemic, yet they recalled the harm that was caused by the poorly tested 1976 vaccine. Decision makers knew they must balance consideration of the potential harms of these two competing scenarios. Within 6 days, the CDC began simultaneously pursuing multiple high-yield methods of developing a vaccine. Since this was a new virus strain, no stored vaccine existed. On April 22, the CDC activated its Emergency Operations Center that focused on virus gene sequencing, surveillance, laboratory issues, communications, at-risk populations, antiviral medications, vaccines, and traveler's health issues (U.S. Centers for Disease Control and Prevention, 2010). At this point, the CDC recognized the potential for rapid spread of the disease, high morbidity and mortality, unusual morbidity age distribution, and multiple pandemic waves. Officials were also aware of the high morbidity and mortality associated with the1976 rapid administration of the poorly tested swine flu vaccine. Beginning in October 2009, millions of doses of antiviral medications were distributed, the necessarily slow process of vaccine development was given high priority, and a media campaign focused on ways to minimize exposure. The first available vaccines were distributed to high-risk groups and health care workers beginning on October 5, 2009. Production and distribution seemed to be a slow process

(*continued*)

that continued through mid-2010 in anticipation of multiple waves of pandemic. No one had a crystal ball. If the new virus had been highly contagious and virulent (like the 1918 outbreak), the public health response would probably have been viewed as heroic. As it turned out, the 2009 H1N1 virus was not as virulent as anticipated and the dollar cost of the CDC campaign was tremendous. It is impossible to know how many lives were actually saved by the mass campaign. Balancing potential harm against potential benefit is like a juggling act done in the dark.

Think About It

Judge the CDC Response

- *What potential large-scale harms and benefits were inherent in this situation?*
- *What factors would you have taken into consideration if you were making the decision about the 2009 H1N1 public health response?*
- *Health care workers and people at known high risk were given first access to the 2009 H1N1 vaccine. How would you describe this distributive justice decision? Was it fair?*
- *Would you have done anything differently in order to protect large numbers of people?*

FIDELITY

The ethical principle of **fidelity** relates to the concept of faithfulness and the practice of keeping promises. Society has granted nurses the right to practice nursing through the processes of licensure and certification. "The authority for the practice of nursing is based on a social contract that acknowledges professional rights and responsibilities as well as mechanisms for public accountability" (ANA, 1995, p. 3). The process of licensure is one that ensures no other group can practice within the domain of nursing as defined by society and the profession. Thus, to accept licensure and become legitimate members of the profession mandates that nurses uphold the responsibilities inherent in the contract with society. Members are called to be faithful to the society that grants the right to practice—to keep the promise of upholding the profession's code of ethics, to practice within the established scope of practice and definition of nursing, to remain competent in practice, to abide by the policies of employing institutions, and to keep promises to individual patients. To *be* a nurse is to *make these promises*. In fulfilling this contract with society, nurses are responsible to faithfully and consistently adhere to these basic principles.

On another level, the principle of fidelity relates to loyalty within the nurse-patient relationship. It gives rise to an independent duty to keep promises or contracts (Veatch, 2002) and is a basic premise of the nurse-patient relationship. Problems sometimes arise when there is a conflict between promises that have been made and the potential consequences of those promises in cases in which carrying them out will cause harm in other ways. Though fidelity is the cornerstone of a trusting nurse-patient relationship, most ethicists think there are no absolute, exceptionless duties to keep promises—that, in every case, the harmful consequences of the promised action should be weighed against the benefits of keeping the promise.

SUMMARY

As we participate in meeting the health care needs of society, we must be constantly aware of the ethical implications inherent in many situations. Each nurse must develop a philosophically consistent framework from which to base contemplation, decision, and action. It is this framework that gives shape to our concept of various ethical principles. The principles discussed in this chapter presuppose nurses' innate respect for persons. Ethical principles include respect for autonomy, beneficence, nonmaleficence, veracity, confidentiality, justice, and fidelity.

CHAPTER HIGHLIGHTS

- Ethical principles are basic and obvious moral truths that guide deliberation and action.
- All ethical principles presuppose a basic respect for persons.
- Respect for autonomy denotes respecting another person's freedom to make choices about issues that affect his or her life.
- Various intrinsic and extrinsic factors threaten patient autonomy.
- The principle of beneficence maintains that one ought to do or promote good, prevent evil or harm, and remove evil or harm.
- The principle of nonmaleficence requires one to avoid causing harm, including deliberate harm, risk of harm, and harm that occurs during the performance of beneficial acts.
- The principle of veracity relates to the universal virtue of truth telling.
- Confidentiality is the ethical principle that requires nondisclosure of private or secret information with which one is entrusted.
- Justice is the ethical principle that relates to fair, equitable, and appropriate treatment in light of what is due or owed to persons,

recognizing that giving to some will deny receipt to others who might otherwise have received these things.

- Fidelity is the ethical principle that relates to faithfulness and promise keeping.

DISCUSSION QUESTIONS AND ACTIVITIES

1. Read the ANA *Code of Ethics for Nurses* (Appendix A) and discuss how the various statements relate to the principles discussed in this chapter.
2. Read the following hypothetical situation and answer the questions that follow:

   An elderly gentleman presents himself to the emergency department of a small community hospital. The patient has contractures and paralysis of his left hand; he apparently has complete expressive and at least partial receptive aphasia. Upon questioning, the man takes off his right shoe and points to his right great toe and grimaces, apparently indicating a problem in that area. The nurse is unable to gather any further information from him because of his difficulty in communicating. In attempting to help him, she asks if he has a neighbor or friend accompanying him. He shakes his head, indicating that he is alone. Curious, the nurse asks him how he came to the hospital. The patient smiles and proudly produces a driver's license from his shirt pocket. Subsequently, the nurse leaves the room and returns a few minutes later to find that the patient left the hospital, having received no care. The nurse suspects that because of his current physical condition the man is unsafe to drive a motor vehicle.

   - What are the ethical implications in this situation?
   - What ethical principles are involved?
   - Should the nurse pursue avenues to locate the patient and ensure that he is not endangering himself or others by driving? Would this be a breach of confidentiality? Autonomy?
   - How does the nurse express fidelity in this situation?
   - What is the beneficent action?
3. Describe situations you have witnessed in which decisions were made for patients in a paternalistic manner. Discuss your perception of the difference between paternalism and advocacy. Give examples.
4. Read the following hypothetical case and answer the questions that follow:

   Martha is a 75-year-old woman who has terminal cancer of the bladder. During the course of her therapy, she sustains third-degree

radiation burns to her lower abdomen and pelvic area. Her wounds are extensive and deep, involving her abdominal wall, bladder, and vagina. The physician orders frequent medicinal douches and wound irrigations. These treatments are very painful, and the patient wants the treatments discontinued but is too timid to actually refuse them. The physician will not change the order.

- Discuss the situation in terms of beneficence and nonmaleficence.
- How does this patient express her autonomy?
- What is the nurse's responsibility in assisting the patient to maintain autonomy?
- How does the nurse deal with conflicting loyalties and principles?

5. Do you think health care professionals should disclose information to patients related, for example, to a poor prognosis, even though the information may cause distress? Discuss your views in depth.
6. Jameton (1984) says that for nurses to be less than competent is unethical. Discuss this statement in terms of fidelity.
7. Read the following hypothetical case and answer the questions that follow:

Nels Gruder is a 40 year-old disabled truck driver. He was injured several years ago in a trucking accident. He subsequently has had back surgery but continues to have severe pain. He has been seen by every local neurosurgeon and, for one reason or another, is not pleased with the care he has gotten. Because of the seriousness of his initial injuries, there is little doubt that Mr. Gruder has chronic back pain. Even though the local emergency room policy of not prescribing narcotic analgesics for chronic pain is clearly stated on signs in the waiting area, Mr. Gruder comes there frequently complaining of severe back pain. He reports a history of gastric ulcers and allergy to nonsteroidal anti-inflammatory drugs (NSAIDs). The nurse practitioner who sees Mr. Gruder is faced with a man who is in obvious pain. She wishes to help him relieve the pain he is experiencing. At the same time she realizes that narcotic analgesia is not appropriate for this type of problem, and is unable to prescribe NSAIDs because of his reports of gastric ulcers and allergy. He says he has tried exercises and a local pain clinic, neither of which was effective. He is aware of the emergency room policy regarding narcotic analgesics for chronic pain, but he comes there in desperation. He insists that his pain is relieved only by narcotic analgesia.

- What ethical principles are involved?
- Does the benefit of pain relief outweigh the harm potentially caused by long-term narcotic analgesic use for this patient?

- Should Mr. Gruder's perceived need for narcotic pain medications be honored even though the nurse practitioner feels he has a problem with drug dependence?
- How does the nurse do what she thinks is right and yet respect Mr. Gruder's autonomy?
- Is it important whether or not the nurse's actions please the patient?

REFERENCES

American Hospital Association. (1973, rev. 1992). *Statement on a patient's bill of rights.* Chicago: Author.

American Nurses Association. (1995). *Nursing's social policy statement.* Washington, DC: Author.

American Nurses Association. (2001). *Code of ethics for nurses.* Washington, DC: Author.

Beauchamp, T. L., & Childress, J. (2008). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.

Beauchamp, T. L., & Walters, L. (2007). *Contemporary issues in bioethics* (6th ed.). Belmont, CA: Wadsworth.

Bok, S. (1991). Lies to the sick and dying. In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (pp. 74–81). New York: McGraw-Hill.

Bok, S. (1994). Truth telling. In W. Reich (Ed.), *Encyclopedia of bioethics* (pp. 1682–1686). New York: Macmillan.

Buber, M. (1965). *The knowledge of man: A philosophy of the interhuman.* New York: Harper & Row.

Cammon, S. A., & Hackshaw, H. S. (2000). Are we starving our patients? *American Journal of Nursing, 100*(5), 43–46.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses.* Ottowa, Canada: Author.

Department of Health and Human Services. (2002, rev. 2003). *General overview of standards for privacy of individually identifiable health information.* [45 CFR Part 160 and Subparts A and E of Part 164]. Retrieved March 17, 2006, from http://www.hhs.gov/ocr/hipaa/finalreg.html

Deshefy-Longhi, T., Dixon, J. K., Olson, D., & Grey, M. (2004). Privacy and confidentiality issues in primary care: Views of advanced practice nurses and their patients [Electronic version]. *Nursing Ethics, 11,* 378–393.

Durant, W. (1926). *The story of philosophy.* New York: Washington Square Press.

Ellin, J. S. (1991). Lying and deception: The solution to a dilemma in medical ethics. In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (pp. 81–87). New York: McGraw-Hill.

Erlen, J. A. (1998). The inadvertent breach of confidentiality. *Orthopaedic Nursing, 17*(2), 47–50.

Erlen, J. A. (2004). HIPAA: Clinical and ethical considerations for nurses [Electronic version]. *Orthopaedic Nursing, 23,* 401–403.

Gillon, R. (1985). Autonomy and the principle of respect for autonomy. *British Medical Journal, 290,* pp. 1806–1808.

Goldsmith, J. (Ed.). (1992). Virginia Henderson, RN: Humanitarian and scholar. *Reflections, 18*(1), 4–5.

Haggarty, L. A. (2000). Informed consent and the limits of confidentiality. *Western Journal of Nursing Research, 22*(4), 508–514.

Harris, S. H. (1999). Japanese medical atrocities in World War II: Unit 731 was not an isolated aberration. Paper presented at the International Citizens Forum on War Carimes and Redress, Tokyo, Japan. Retrieved from http://www.vcn.bc.ca/alpha/speech/Harris.htm

Harrison, A. F., & Bramson, R. M. (1982). *Styles of thinking.* New York: Doubleday.

Henderson, V. (1966). *The nature of nursing: A definition and its implications for practice, research, and education.* New York: MacMillan.

International Council of Nurses. (2006). *The ICN code of ethics for nurses.* Geneva, Switzerland: Author. Retrieved from http://icn.ch/icncode.pdf

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Lipkin, M. (1991). On lying to patients. In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (pp. 72–73). New York: McGraw-Hill.

Markus, A., & Lockwood, M. (1991). Is it permissible to edit medical records? *British Medical Journal, 303,* 349–351.

Muldoon, J. D. (1996). Confidentiality, privacy and restriction for computer-based patient records. *Hospital Topics, 74*(3), 32–37.

Munson, R. (1992). Major moral principles. In *Intervention and reflection: Basic issues in medical ethics* (4th ed., pp. 31–45). Belmont, CA: Wadsworth.

Neustadt, R. E., & Fineberg, H. V. (2005). *The swine flu affair: Decision-making on a slippery disease.* Honolulu, HI: University Press of the Pacific.

Nuremberg Military Tribunal. (October 1946–April 1949). *Trials of War Criminals Before the Nuremberg Military Tribunals* (Vol. 2, pp. 181–182).

Washington, DC: U.S. Government Printing Office. Retrieved from http://www.loc.gov/rr/frd/Military_Law/NTs_war-criminals.html

O'Keefe, M. H. (2001). *Nursing practice and the law: Avoiding malpractice and other legal risks.* Philadelphia: F. A. Davis.

Percival, T. (1803). *Medical ethics: A code of institutes and precepts adapted to the professional conduct of physicians and surgeons* (3rd ed.). Oxford: Shrimpton.

Shuster, E. (1997). Fifty years later: The significance of the Nuremberg Code. *New England Journal of Medicine 337.*, 1436–1440. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJM199711133372006

Taubenberger, J.K., & Morens, D. M. (2006). 1918 influenza: The mother of all pandemics. *Emerging Infectious Diseases*. Retrieved from http://www.cdc.gov/ncidod/EID/vol12no01/05-0979.htm

Tobriner, M. O. (1991). *Majority opinion in Tarasoff v. Regents of the University of California.* In T. A. Mappes & J. S. Zembaty (Eds.), *Biomedical ethics* (pp. 165–169). New York: McGraw-Hill.

United States Holocaust Memorial Museum. (2010). The doctors trial: The medical case of the subsequent Nuremberg proceedings. Retrieved November 4, 2010, from http://www.ushmm.org/research/doctors/

U.S. Centers for Disease Control and Prevention. (2010). The 2010 H1N1 pandemic: Summary highlights, April 2009–April 2010. Retrieved from http://www.cdc.gov/h1n1flu/cdcresponse.htm

Veatch, R. (2002). *The basics of bioethics* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Weindling, P. (1996). Human guinea pigs and the ethics of experimentation: The *BMJ's* correspondent at the Nuremberg medical trial. *British Medical Journal, 313*(1), 1467–1470.

Weyers, W. (2007). *The abuse of man: An illustrated history of medical experimentation*. New York: Ardor Scribendi.

Winston, M. E. (1988). AIDS, confidentiality, and the right to know. *Public Affairs Quarterly, 2*, 91–104.

Zomorodi, M., & Foley, B. J. (2009) The nature of advocacy vs. paternalism in nursing: Clarifying the "thin line." *Journal of Advanced Nursing, 65*(8), 1746–1752.