mine treatment when the patient is unable to make such decisions directly. The important issue, then, is whether an appeal to such a strategy represents the autonomy of the patient in question. The particular feature that, I will argue below, makes an AD inconsistent with autonomy (namely, the inability to reconsider the commitment to this strategy at the time of application) is a feature common to ADs in generic fashion (whatever particular form the AD might take).

In this context, one more caveat is in order. I do recognize that there are ways in which people may bind themselves that *are* consistent with autonomy. It is important to note, therefore, that it is not *simply* the appeal to a strategy for making healthcare decisions that I find to threaten autonomy. Indeed, as I will discuss below, commitments to certain types of strategies are perfectly consistent with autonomy. For example, a patient might defer to a physician's judgment as an indirect strategy. In normal circumstances, this is perfectly consistent with the patient's autonomy. However, not all cases of "self-binding" behavior are consistent with autonomy, with voluntary slavery serving as but one example. As we shall see below, to remain consistent with an agent's autonomy, the strategy in question must include an ability to reassess one's commitment to the strategy, a characteristic absent (again, by definition) in the application of advance directives, whatever particular form an AD might take.

The above has serious implications for the autonomous determination of action through various formal mechanisms and strategies. As we shall see below, although all formal strategies reflect the agent's *adoption* of that strategy, the ways in which different strategies *operate* within the agent's practical reason can be very different. Some types of formal strategies for determining action are indeed consistent with autonomy, others are not. I will argue that because of certain defining characteristics, advance directives specify *how* the determination of treatment is reached (a formal strategy for determining action), but cannot reflect an *autonomous* determination of treatment. Put differently, because of the conditions that define the application of advance directives, ADs might be taken to reflect the agent's *adoption of a formal strategy for determining action*, but not the *type of* formal strategy that reflects the agent's autonomy in determining action itself. To understand this, we must examine how phenomena like advance directives fit into an agent's practical determinations.

Practical Reasons and Strategies

We shall now leave, briefly, the direct examination of ADs per se to come to a better understanding of how strategies of practical reasoning operate in terms of their affect on an agent's autonomy. As we shall see, certain strategies reflect autonomous practical reasoning, but others do not. After we examine how these different types of strategies should be understood, we will return to our focus on advance directives to see why the characteristic features of the type of strategy an AD represents reflect the type of commitment to a strategy that is not consistent with autonomy.

Autonomous decisions reflect the agent's assessment of the balance of reasons for action, "reasons" here construed in the broadest possible sense. But in real life, an agent's determination of action does not always reflect a simple assessment of the balance of reasons. For example, we sometimes use indirect strategies, or adopt rules of thumb that do not fit the model of a simple assessment of reasons (we shall discuss examples of such phenomena below). As we shall see, advance directives look to be phenomena of this sort, allowing the patient to determine treatment through commitment to a particular strategy: by reference to the advance directive. To account for phenomena like indirect strategies and rules of thumb, Joseph Raz devised a model of "second-order reasoning"[1] that we shall examine in detail.

Although the notion of second-order reasons was recognized as a significant contribution to philosophical work in the area of practical reason and action, there remains confusion as to exactly how we are to understand what a second-order reason is, and how it relates to other reasons we have to perform various actions. The various examples used by Raz to illustrate second-order reasoning emphasize different aspects of the relationship of second-order reasons to other reasons for action that we may have; that diversity clouds

[1]Raz J. *Practical Reason and Norms*. Princeton, New Jersey: Princeton University Press, 1990.

the role second-order reasons play within practical reason. At times, it seems that second-order reasons are phenomena of indirect strategies to achieve an end that an individual may not achieve through direct strategy in determining action. Yet at other times it seems that second-order reasons impose obligations independent of other reasons and strategies for achieving a given end. In examining the concept of second-order reasons, I will attempt to clarify this notion by maintaining that the apparent ambiguity in the examples of second-order reasons given by Raz is due to the different ways this type of reason might relate to other reasons for action. This distinction, which is not in Raz's work, can help to identify the times when second-order reasoning reflects the substantive assessment of the agent, and also those times when second-order reasoning does not. Ultimately, I will argue that advance directives must be characterized as the latter.

The Concept of Second-Order Reasons

Raz explains second-order reasons as reasons to act on particular reasons for action or to refrain from acting on particular reasons for action.[2] In this way, second-order reasons can be distinguished from first-order reasons, in that whereas a first-order reason affects our determination of action through the weight of that reason, second-order reasons affect our determination of action through the effect the (second-order) reason has on other (primarily first-order) reasons. Thus, they are formal strategies to be used to evaluate reasons in a particular way. They do not directly determine action themselves, but rather provide a formal mechanism for identifying *how* (first-order) reasons should be evaluated.

Advance directives seem to be such strategies, as they are designed to be used to evaluate options when an agent is unable to make such evaluations directly. Advance directives specify either what criteria should be used to evaluate treatment, what specific treatment should be given preference or avoided, or who should make surrogate decisions concerning treatment in case the patient herself is unable to make such decisions. In this, ADs specify *how* decisions concerning treatment should be made in formal terms.

The question that arises, then, concerns exactly how ADs operate as second-order reasons within an agent's practical reason. Below we shall examine two different ways in which second-order reasons may operate within an agent's practical reason. The first, which I shall call "indirect strategies," are consistent with an agent's autonomy. But the second, which I shall call "relinquishments of judgment," are not. I will argue that ADs must be understood as the latter type of second-order reason, which is not consistent with autonomy.

Raz gives several examples to illustrate the concept of second-order reasons. The first of these is the case of Ann, who attempts to determine whether to take a proposed investment opportunity:

> Imagine the case of Ann who is looking for a good way to invest her money. Late one evening a friend tells her of a possible investment. The snag is that she has to decide that same evening for the offer to make the deal will be withdrawn at midnight. The proposed investment is a very complicated one, that much is clear to Ann. She is aware that it may be a very good investment, but there may be facts which may mean that it will not be a good bargain for her after all, and she is not certain whether it is better or worse than another proposition which was put to her a few days before and which she is still considering. All she requires is a couple of hours of thorough examination of the two propositions. All the relevant information is available in the mass of documents on her table. But Ann has had a long and strenuous day with more than the average amount of emotional upsets. She tells her friend that she cannot take a rational decision on the merits of the case since even were she to try and work out the consequences of accepting the offer she would not succeed; she is too tired and upset to trust her own judgment. He replies that she cannot avoid taking a decision. Refusing to consider the offer is tantamount to rejecting it. She admits that she rejects the offer but says that she is not doing it because she thinks the reasons against it override those in its favor but because she cannot trust her own judgment at this moment.[3]

[2]See note 1. Raz 1990: 39.

[3]See note 1. Raz 1990: 37.

In the above case, the basis of Ann's decision to reject the proposed investment offer is not the weights of the various reasons for and against making the investment. Rather, Ann has a reason (she is tired and cannot trust her own judgment) that affects the reasons for and against making the investment. That Ann is tired and cannot trust her own judgment is a second-order reason to *not directly assess the balance of reasons* for accepting or rejecting the proposed investment.

In Raz's example, the second-order reason functions as an indirect strategy. Ann obviously wishes to get the highest return on her investment. The determination of which investment opportunity will benefit her most (the investment proposed by her friend or the other proposition which was put to her a few days before) would normally be calculated by evaluating each alternative in regard to the end to be achieved. However, because Ann is tired and does not trust her own judgment, she maintains that she will likely fail to correctly determine which investment would result in the best consequences. Therefore, she feels that she will benefit most by not attempting to calculate which investment will benefit her most at this time, *precisely because she does not trust her own judgment*. This reason affects the weight of the reasons for taking or not taking the proposed investment by making them irrelevant to her determination of action.

Let us consider a similar example in medicine. In making healthcare decisions, many people might find that they wish to defer to the judgment of a physician, stating, in essence, "Do what you feel best, Doc. I trust your judgment." This represents an appeal to an "indirect strategy," in which the patient feels her goals will best be achieved if she does not make healthcare decisions herself, but rather defers to the physician. Perhaps she lacks an adequate knowledge of medicine, or recognizes that because she is ill she does not trust her own judgment. Therefore, she decides to defer to the physician's judgment and not to act on her own assessment of the reasons for and against various treatment alternatives.

Importantly, however, the patient retains the ability to reconsider this appeal if she should come to lose confidence in the judgment of the physician, or even come to decide that she does in fact trust her own judgment on the matters in question. It is this ability to reconsider the commitment to the strategy in question that distinguishes this strategy from voluntary slavery, as we shall see below. Likewise, it is this ability to reconsider the strategy at the time of application that distinguishes merely deferring to a physician's judgment from advance directives. Let us consider how advance directives operate differently in the context of an agent's autonomy.

A Second Concept of Second-Order Reasons

Later in the same chapter of *Practical Reason and Norms,* Raz offers another example of a second-order reason that seems to function in a slightly different way:

> consider the case of Colin who promised his wife that in all decisions affecting the education of his son he will act only for his son's interests and disregard all other reasons. Suppose Colin has now to decide whether or not to send his son to a [private] school. Among the relevant reasons are the fact that if he does he will be unable to resign his job in order to write the book he so much wants to write, and the fact that given his prominent position in his community his decision will affect the decisions of quite a few other parents, including some who could ill afford the expense. However, he believes that because of his promise he should disregard such considerations altogether (unless, that is, they have indirect consequences affecting his son's welfare). Again, some will think that his promise is not binding, but that is beside the point. Our aim is simply to understand the reasoning of those who believe in such reasons, and it must be admitted that they are numerous.[4]

Again in this example, the agent's reason for action (Colin's promise) does not determine the agent's action directly, but rather serves as a reason for the agent to act for a particular reason for action (for the reason "that it is in his son's interests") and exclude other reasons for action that the agent may have from his determination of action. Colin's promise influences his determination of action through its effect on other (first-order)

[4]See note 1. Raz 1990: 39.

reasons for action (it is a reason to act for a particular first-order reason and exclude others), and thus is a second-order reason.

Although there are obviously many similarities between the case of Ann and the case of Colin, there are also important differences. Foremost among these is the fact that in the case of Colin, the second-order reason in question does not appear to function as an indirect strategy, but rather seems to change the normative situation by establishing new criteria by which to determine action.

While in the case of Ann the second-order reason did not change the end to be achieved (but only changed the strategy to achieve this end), the case involving Colin is quite different. Here it appears that by placing an obligation upon Colin to decide on the basis of his son's welfare, the second-order reason (Colin's promise to act only for his son's interests and to disregard other reasons) does not establish a strategy by which to achieve the end Colin sets, but instead establishes the very end that Colin is to pursue.

The above cases illustrate two fundamentally different ways in which second-order reasons can function within an agent's practical reasoning. As I shall discuss below, indirect strategies do not eliminate an agent's practical evaluation from the determination of action in the manner that Colin's promise does. Although Colin's promise may be taken as a second-order reason because of Colin's evaluation that it should be taken as such, it nevertheless then *replaces* Colin's evaluation judgment in the practical evaluation of alternatives; the second-order reason identifies what is relevant to Colin's determination of action. This is similar in structure to voluntary slavery (and, I shall argue, advance directives). Let us consider how.

The difference in the ways second-order reasons might function in the context of an agent's practical reason is especially important when attempting to understand the way strategies affect an agent's autonomy. "Strategies" that operate as indirect strategies are affected by different sorts of considerations than are "strategies" that operate as relinquishments of judgments (such as Colin's promise). A second-order reason that functions as an indirect strategy will be affected by considerations which indicate that the indirect strategy the second-order reason represents is not, in fact, the appropriate strategy for achieving the end desired. Thus, considerations such as the fact that no investment opportunities will be available if Ann does not decide right away may indicate that a strategy of "not weighing the pros and cons for taking an investment at the present time" is not the strategy that will likely give her the best results, even though Ann remains tired (either investment may be considered better than no investment). Second-order reasons that function as indirect strategies may be undermined through reference to the end that the agent's own evaluational judgment establishes. Thus, such indirect strategies allow the agent's own judgment to continue to determine action, as the application of the strategy in question reflects the agent's assessment that appeal to the strategy is the way to determine action. Since the second-order reason does not establish the actual end to be achieved, the second-order reason does not inhibit the agent from changing his or her evaluation of various alternatives, including her evaluation of appealing to the strategy.

Second-order reasons that function as relinquishments of judgment, however, are not susceptible to such considerations. A second-order reason that functions in this way *establishes* the end to be achieved, and in this way eliminates the agent's evaluation from influencing the determination of action. Although the agent's evaluation may establish the second-order reason, this kind of second-order reason establishes an end that is then independent of the influence of the agent's assessments. The *strategy* identifies what to attach value to, rather than the agent. Thus, second-order reasons that function as relinquishments of judgment are analogous to placing oneself on "automatic pilot." While the second-order reason may be adopted on the basis of the agent's own evaluational judgment, the agent's judgment is then eliminated from the determination of action.

Let us consider an example. Suppose Colin's promise to act on the basis of his son's interests is adopted as an indirect strategy. Perhaps because Colin does not hold a position of importance in the community, and because other influences on his decisions are also insignificant, and because it takes a great deal of time to actually balance these considerations, Colin determines that in matters affecting his son, it would be best simply to adopt

a strategy of acting on the basis of his son's interests. Since his son's interests hold great value for Colin, this strategy will most likely give the result Colin wishes (just as Ann's strategy was adopted because she believed her goal would most likely be achieved through it, given her tired condition).

Now suppose Colin's circumstances change, in that his position in the community becomes significant; so significant that his decision's effect on the community becomes, in the greater scheme of things, even more important to Colin than his son's interests. Colin will now likely determine that his strategy of always acting on the basis of his son's interests will not be likely to give him the appropriate result. That strategy, then, will likely be discarded.

However, if Colin's promise is adopted as a "relinquishment of judgment," he cannot discard the strategy on the basis of the change in his position in the community. His promise is to act on the basis of his son's interests, and to take that as his end. His own evaluation of what is more important, then, is no longer reflected by the strategy. This fact illustrates that the decisions taken under the direction of this strategy are not *decisions* that reflect Colin's ends (although the adoption of the strategy itself does). Rather, the decision taken under the direction of the strategy in question reflects the end established *by the strategy*. And this end might or might not coincide with Colin's. Evidence that it does not, unlike the effect of such evidence on indirect strategies, does not affect the strategy's application. In this, although the adoption of the strategy itself reflects the agent's ends, the specific decisions made under the direction of that strategy do not; these decisions reflect the ends established *by the strategy*. This type of strategy is akin to voluntarily entering into slavery (for the purposes of the strategy's effect on the agent's reasoning).

The determination of behavior under slavery cannot be considered autonomous, even if the agent in question has voluntarily entered into this relationship. Although the agent may choose to have behavior determined through a "slave relationship," the actual determination of behavior under this relationship is made by the "master," not the "slave." Importantly, the slave is obligated to act on the master's directives without the ability to reconsider this relationship; the behavior required need not reflect any ends of the slave. (I understand slavery here as implying an inability to reassess whether to be in the relationship. A relationship that would allow this reassessment would not qualify as "slavery." Even cases of slavery for a limited, specified time or for specified realms of life, do not allow a choice to leave the relationship within the time specified, or within the realm specified.) The slave may *hope* that the master's directives are such that they are consistent with the reasons for which she has entered into this relationship, but the obligation to do as the master directs is not contingent upon this. Indeed, the obligation holds even if she finds the master's directives to be directly at odds with her reasons for entering into the relationship. This feature makes an appeal to this type of strategy inconsistent with autonomy (so far as the "slave" is concerned).

One may argue that the ability to relinquish judgment in certain areas of life is necessary to make life richer. I will not argue this point here, as it may well be true. But if this is used as the basis for justifying advance directives, the concept itself should be removed from the realm of self-determination, and discussions of advance directives taken up on issues surrounding whether this is an area in which such an ability enriches life. To argue that an ability to relinquish judgment is an important aspect of a rich life is not to argue that relinquishing judgment is consistent with autonomy, but is to argue that relinquishing autonomy is at times justified. There will remain, however, many instances where this is not justified, and for some of these areas, in particular for phenomena like *true* voluntary *slavery*, we will view this as unjustified *precisely because* it represents a relinquishing of autonomy and through this a fundamental human right (thus, for example, we do not allow persons to sell themselves into slavery).

ADs are not slave relationships. But the appeal to an AD represents a commitment to a strategy that is similar in structure to slave relationships, for the purpose of considering the effect of the strategy in question on an agent's autonomy. One important difference between ADs and slave relationships is that an AD may be changed at any time while the patient retains competency. However, *at the time of an AD's application*, the commitment to this strategy cannot be reconsidered,

and thus at this time the AD becomes analogous to a slave relationship. (And it is at *the time of application* that an AD becomes important! While the patient retains competency, for example, her active decisions take precedence over an AD. We shall discuss the important features of ADs at the time of application in greater detail below.) Because this type of strategy cannot be reconsidered by the agent, in the manner that simply deferring to a physician's judgment might be, the determination made under the application of the AD cannot be considered to reflect the patient's autonomy. Let us consider in greater detail why this is so.

Advance Directives as Formal Strategies

We have seen that advance directives, if they are to be subsumed under the right to informed consent and patient autonomy, should be understood as a strategy for determining action that amounts to a second-order reason. We have also seen that, although some second-order reasons function within an agent's practical reasoning in such a way that they are consistent with the agent's autonomy, other second-order reasons do not. In the section above, I indicated that one of the characteristic differences between second-order reasons as indirect strategies and second-order reasons as relinquishments of judgment is the way they might be affected by continuing evaluations on the part of the agent. This latter type of second-order reason, although adopted in an autonomous manner by the agent in question, does not continue to reflect the agent's autonomy in the determination of the agent's action. Rather, the second-order reason *replaces* the agent's practical evaluations in the actual determination of action.

The characteristic feature of the type of second-order reason which is *not* consistent with autonomy is that, in *replacing* the agent's practical evaluations in the actual determination of the action, *the second-order reason* identifies the "proper" way to determine action. In this, the agent's practical evaluations are no longer reflected in the determination of action when the second-order reason is applied. Rather than functioning as an indirect strategy that allows the agent's practical evaluations to trump the second-order reason, thus reflecting the agent's evaluation that the strategy in question is the proper way to evaluate what action to take, this type of second-order reason *replaces* further evaluations on the part of the agent from influencing the determination of action. Because the agent no longer continues to evaluate the strategy in question as the proper way to determine a given action, only the *adoption of the strategy*, and *not* the *determination made on the basis of this strategy*, can be considered to reflect the agent's autonomy.

Advance directives *must* be understood as the type of second-order reason that is not consistent with autonomy. This is so because the application of an AD is effective only when an evaluation on the part of the patient is impossible. For example, the Ohio State Bar Association "Standard Form for Durable Power of Attorney for Health Care" and "Living Will Declaration" forms explicitly state that "This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself. . . ."[5] While it is true that you might regain the ability to make decisions for yourself, when you do the AD is no longer effective. The *defining feature* of the AD's effectiveness is the patient's inability to make evaluations of her options, and this includes the inability to make evaluations that the strategy adopted continues to be the proper way to determine treatment.

Thus, a proper understanding of the various ways in which individuals might adopt strategies for making practical evaluations through the model of second-order reasons clearly illustrates that, while some types of strategies for making practical evaluations might reflect an agent's autonomy, advance directives cannot. This does not mean that advance directives should immediately be jettisoned from our concerns with "moral" healthcare. It simply means that advance directives, because of their defining characteristic features, cannot be subsumed directly under the right to patient autonomy. We must be cautious, then, in ascribing to advance directives the moral weight of a competent patient's decisions. The patient's inability to assess the application of the AD in the particular instance places the patient in a situation in regard to the AD that is analogous to

[5]Ohio State Bar Association, Ohio State Medical Association. Advanced directives for health care: Standard forms (special insert). *Ohio Lawyer* 1991.

the voluntary slave. Advance directives do reflect the autonomous adoption of a particular strategy for determining treatment. But this strategy does not itself reflect the autonomous decision of a patient in identifying what treatment is preferred or consented to.

Advance Directives as Predictors

If advance directives do not reflect patient autonomy, why should they be given any weight at all? The answer to this question lies in understanding that autonomy is not a magical concept that alone confers value on informed consent. Autonomy confers value because it reflects certain cultural values and social structures. I will argue below that advance directives might, in a different way, reflect these same cultural values and social structures, and thus warrant our concern.

It is not always possible to incorporate autonomy into some particular systems, and the medical system is one in which incorporating autonomy at times becomes problematic. For example, some patients are hospitalized *because of* psychological disorders that undermine their ability to make autonomous decisions. And, most importantly for the discussion here, some patients are, due to a vegetative state, a coma, or some other condition, unable to make autonomous decisions concerning continued treatment. It is here where advance directives become important.

While advance directives do not reflect autonomy per se, they do offer a mechanism for incorporating what would *likely be* the patient's values and preferences in circumstances where these values and preferences cannot be incorporated directly. This provides a reason to give weight to advance directives despite the fact that they do not reflect autonomy per se, for reasons similar to those for which we ascribe such great weight to actual autonomy.

The reason we place such great weight on autonomy in society generally is that we are most comfortable when events affecting individuals are determined through autonomous choices on the part of those individuals. Consider the various ways in which society attempts to minimize the influence of "luck" on a person's well-being. When events do reflect autonomy, we are able to parcel responsibility, structure society to deal with problematic cases, and feel confident that the events in question reflect the values and wishes of the person affected. At the very least, if events then go wrong the loss is attributable to the person herself, and not mere "bad luck" or misfortune. While such confidence is not perfect to be sure, society seems best organized, given the role autonomy plays in our understanding of the world and the ways in which we structure society, if the events that affect a person reflect that person's autonomous choice.

Further, and perhaps more importantly (for this is likely the basis for our greater comfort with autonomous decisions), autonomy is important because a recognition of the unique values and beliefs of the patient is an immensely important component of assessing the benefits and burdens of treatment options. Because the effect of treatment on a patient's quality of life will depend on the particular values that give meaning to that patient's life, we can be more confident that treatment offers appropriate benefits when treatment decisions reflect the patient's autonomous choice.

Given the above, it seems quite possible that we would feel more comfortable in cases where autonomy cannot be incorporated, to as closely approximate the autonomous choice the person in question *would take,* if a mechanism were available to determine what that person's autonomous choice would be. Advance directives provide precisely such a mechanism. By acting as predictors of what the patient would choose were she able to take a choice, advance directives provide a mechanism through which the decisions made concerning the treatment of a patient unable to take decisions on her own behalf, may be understood as more consistent with the ways in which society usually takes such decisions, and we can be more confident that treatment decisions will reflect an adequate assessment of the benefits and burdens of treatment on the patient's quality of life.

The reasons to recognize ADs are indeed born of the desire to make healthcare decisions in a manner consistent with the autonomy of the patient, in circumstances in which autonomous decisions are impossible (by definition of the AD's applicability). The only alternative to honoring the AD seems to be the imposition of a paternalistic decision by some third party (such as a physician or judge). Such an alternative would seem less likely to be consistent with the autonomy of the patient than honoring the AD. This argument in

favor of recognizing ADs is supported by a recent study published in the *New England Journal of Medicine*,[6] which finds that ADs promote the ability to identify a patient's preferences (either by providing a basis for predicting these preferences through the patient's prior articulation of preferences, or by promoting discussion of these preferences with chosen surrogates[7]). In addition, this study finds that in the absence of an AD, third-party decisionmakers cannot adequately predict a patient's preferences on the basis of the patient's age, health, or other demographic features. Thus, the value of recognizing ADs would seem consistent with the concern to incorporate patient self-determination into healthcare decisions.

It remains true, however, that advance directives do not reflect autonomy per se, but rather act as predictors of what autonomous decisions would be taken. Thus, there should be important differences in the way we view advanced directives and the way we view autonomy. The most important of these differences concerns the criteria used to evaluate the legitimacy of determining treatment by the mechanism in question. In the case of autonomous decisions, this criteria consists primarily of "competency to make decisions." While the standard of competency is itself controversial, it is generally accepted that if a patient *is* competent to make a decision, his or her decision is the proper way to determine treatment.

For advance directives, however, additional criteria must be imposed, because ADs are mere predictors, in order to ensure that the AD is a reasonable predictor of what decision the patient in question would take. We must recognize that the decision taken in terms of the AD is a decision taken prior to, and independent from, the actual conditions that obtain. Thus, where consistency with other decisions and prior experience with similar situations are not required for autonomous decisions to take precedence (unless, for example, inconsistency should call into question the patient's *competency*—but we shall assume here that the patient *is* competent), these factors may become important for assessing the legitimacy of advance directives as the proper mechanism for determining treatment.

There are many cases in which we all believe, on the surface, that we would make decisions differently than we actually do. For example, I may believe, before reflection, that if I were given the opportunity to take a position with a six-figure salary I would jump at the chance! But when actually presented with the opportunity, I may find that considerations such as family, friends, security, stability, or things that I had not considered weigh more heavily than I supposed. When I am able to make an active decision, these considerations may weigh in. But advance directives require that the decision be made prior to the actual circumstances. Therefore, we should be confident that this prediction of what decision would be taken be fully considered.

Consistency with other decisions can indicate whether the patient had given sufficient thought to the AD to make it a reliable predictor of what decision she would take. It indicates that when similar values have competed, decisions taken are consistent with the decision expressed through the AD, and so seems more likely to predict the actual decision that patient would take. Similarly, prior experience with similar situations indicates that the patient is aware of the factors which might "weigh in" in the circumstances, and so seems more likely to know what decision she would take.

Likewise, in recognizing the validity of a chosen surrogate's decision (under a durable power of attorney, for example), we should take care to see that the surrogate attempts to take a decision which is consistent with the patient's values and preferences. If the surrogate's decision is clearly contrary to what these values and preferences would likely be, we should question the validity of the surrogate's decision. For what reason is there to recognize a chosen surrogate's decision over a third party's decision if it is not related to the patient's values and preferences?

It may be objected here that the choice of a surrogate decisionmaker may not be based upon that surrogate's knowledge of the patient's preferences, but rather on the fact that the patient wishes the decision to reflect that party's values. For example, a patient may designate a family member as surro-

[6]Emanuel L. et al. Advance directives for medical care—A case for greater use. *New England Journal of Medicine* 1991; 324(13):889–95.

[7]It should be noted, however, that in the absence of direct discussion with patients, substituted decisionmaking is not likely to correspond with the patient's preferences. This may be relevant to the criteria we wish to impose on the recognition of a chosen surrogate's decisions.

gate, because she wishes treatment decisions to reflect her family's preferences. Such a basis for designating a surrogate is perfectly consistent with the model I offer, for it is quite appropriate for even active decisions to be based on a consideration of the preference of one's family. And if it is likely that one's active decision would reflect the preferences of one's family, to recognize the decision of a surrogate appointed for this reason is indeed to incorporate the likely decision the patient would take. What may become important, then, is for a patient to identify *why* a particular surrogate has been designated, and then to examine the surrogate's decision in regard to its consistency with these reasons (in effect, establishing that the decision made by the surrogate likely reflects the ends for which the strategy embodied by the designation of this surrogate was adopted).

A full list of the criteria that should be required to ensure that advance directives are reliable predictors of autonomous decisions will require a discussion which incorporates studies by psychologists, healthcare professionals, healthcare clinicians, sociologists, and others. I will not attempt to offer a model of what is needed to establish the reliability of ADs as such predictors. The above discussion represents, rather, speculative suggestions meant to provide an example of the types of criteria that might be imposed in order to recognize the validity of advance directives as the proper mechanism for determining treatment. The actual criteria imposed, again, must reflect empirical research into what is needed to establish the adequate reliability of advance directives to incorporate the patient's values and preferences. There is a significant lack of empirical research concerning these questions, and therefore a need to redirect empirical research on advance directives toward questions such as: How should surrogates be selected to reflect the patient's values? How can ADs be designed to reflect more stable preferences, likely to still be held by the patient? What factors increase the likelihood that advance directives are accurate predictors of the patient's decision?

The important point for the purpose of this paper is that ADs do seem to provide a mechanism for incorporating the values of the patient into healthcare treatment decisions when these values cannot be incorporated directly. This role establishes the value of recognizing ADs, and in this also establishes the need for additional criteria to ensure the reliability of ADs in this role, because they do not reflect an autonomous decision concerning treatment per se. Recognizing this role, in turn, can help us to identify the types of criteria that might appropriately be imposed to recognize the validity of advance directives as the proper mechanism for determining treatment.

The implication of this understanding of advance directives is that there is a range of cases in which we might appropriately disregard an advance directive on the basis of reasons that would not make it appropriate to disregard active decisions by the patient. This does not, however, compromise the cultural values that ground our concern with patient self-determination. Advance directives are a mechanism by which we attempt to incorporate the values and preferences of patients in circumstances where these values cannot be incorporated directly, and the criteria imposed reflect the appropriateness of ADs for establishing what these values and preferences likely are. In this, disregarding advance directives because they do not meet the criteria meant to establish their reliability in this role is no more a threat to the cultural values in question than requiring that active decisions be made by "competent" patients in order to be recognized as valid.

Discussion Questions

1. What, exactly, are advance directives? What is their role in the health care profession?
2. How would you characterize the relationship between an advance directive and a patient's autonomous decision about her treatment?
3. May's discussion of second-order reasons illustrates a potential problem for advance directives and the autonomous determination of treatment. What, exactly, is the potential problem? Do you agree with May that this is a legitimate problem?
4. If advance directives do not, in fact, function as indicators of autonomous decisions, what role do they play, if any?

An Ethic of the Fitting: A Conceptual Framework for Nursing Practice

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BOTH THE TELEOLOGICAL THEORY in its utilitarian form and deontology are concerned with how a nurse ought to act. They provide a morality of doing. Utilitarianism is founded on the "primary irreducible element—good" as the reference against which a right or wrong action is judged. Deontology on the other hand has duty as its primary irreducible element, such that right action comes from duty and the action or doing is universal.

In stark contrast, the virtue- (character) based theory concerns itself not with the question "what ought a nurse do?" but rather "who ought a nurse be?" Hence, the virtue theory of ethics provides for a morality of being. As such, this theory concerns itself with the character of the virtuous agent. The necessity of involving character is important as "virtues give perfection to the soul" in situations in which no theory of good or theory of right are in themselves complete guides to action without being supplemented by a theory of virtue.[1]

Virtue Ethics

The act theory of utilitarianism aims to maximize utility achieved via the promotion of maximizing the good for the greatest number. In answering the question, "what ought a nurse do?," the nurse guided by utilitarianism acts to maximize the consequences of the act that promote(s) the interests of all those affected by it.

The act theory of deontology has as "the preferred motive for moral action duty itself." The right action is that which comes from this duty, based on pure reason. In answering the question "what ought a nurse do?" the nurse is guided by a theory of deontology and acts from duty and reasoned rules that are universal.

Virtue-based theory recognizes the type of person a nurse is as central to an appraisal of morally acceptable action. Thus, a focus on character traits exhibited by an individual marks a distinction between virtue-based theory ("who ought I be?") and deontological- and consequential-based theory ("what ought I do?"). Virtue-based theory can assist in the moral life of a nurse as choices or conflicts between rules or principles of obligations are not necessarily clarified by those theories sometimes described as act theory. Further, virtue-based theory has precedence as "rules or principles within act-theory do not in themselves tell us how to apply them."[2]

A further criticism of act theories is that they fail to adequately take into account the ordinary moral life as involving an individual's character. For some, the virtues are "the stuff of which much of the moralities of everyday life are made"[3] while for others virtue ethics is entitled to a limited priority over the aforementioned act-orientated theories.[4] As such, the recognition of character traits

[1]Dods M. The works of Aurelius Augustine: Of the morals of the Catholic church. In: Sommers C & Sommers F (eds). *Vice and Virtue in Everyday Life*. New York: Harcourt Brace College Publishers, 1993; 226–230; Trianosky G. What is virtue ethics all about? *American Philosophical Quarterly* 1990; 27:335–334.

[2]Trianosky, op. cit.

[3]Ibid.

[4]Hinman L. *Ethics: A Pluralist Approach to Moral Theory* San Diego: Harcourt Brace College Publishers, 1994

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serves to emphasize the individual as an agent immersed in the moral life rather than acting in some detached way. The application of the utilitarian standard or deontological constraints to a given moral context involves a somewhat reductionistic, mechanical problem-solving approach that lacks a sensitivity to the very nature of relationships.

Consider the nurse, motivated by the virtue of compassion for another person, who tells either the truth or a direct lie. Compare this agent to another who acts similarly, but is motivated by greed. It would seem reasonable to suggest that morally praiseworthy recognition would be awarded to the nurse rather than the agent, even though both have performed the same action, because it can be claimed there is goodness within the nurse.

That is, there is a definite sense in which the motivation by the virtue of compassion is superior to that of greed. This "sense" asserts that fundamental to ethical consideration is a reflection on who the nurse is over and above what the nurse ought to do. Although consequences are not immaterial in the ethical consideration, they remain an incomplete aim for the fuller ethical appraisal.

Compassion, unlike greed, is considered a virtue. Accordingly, compassion not greed tends to foster the good human life. It is compassion by its nature as a virtue that:

> connects and interlocks with a variety of human goods in such a way that its removal from our lives would endanger the whole structure . . .[5]

It is unreasonable to conclude the same about greed. Therefore, it follows that judgments about the morality of an action have some reliance on a nurse's motives.

Further, imagine a nurse who acts according to a principle or obligation but does so without genuine respect for others. That is, the nurse fails to act out of friendship or sensitivity to the needs of others but adheres to the rules or principles that guide action. Moreover, consider the individual who, obligated by the rule of veracity, tells the truth in all situations. A nurse has this obligation as decreed by the deontological constraint, "Thou shall not lie." Arguably, this obligation may produce the right action but action alone does not best describe moral worthiness. Rather what is sought is the virtuous nurse who becomes

> (the) person we trust . . . one who has an ingrained motivation and desire to perform right actions. Not the rule follower, then, but the person disposed by character to be generous, caring, compassionate, sympathetic, fair and the like, is the one . . . [to] recommend, admire, praise and hold up as a moral model.[6]

Criticism of Virtue (Character) Ethics

The criticism that virtue ethics fails to say much about what an agent ought to do assumes a proposal to locate virtue ethics as a pure or substitute ethical theory. As it will become clear, this criticism is inappropriate as virtue ethics is not cited as a theory of right action. Further, Louden states that virtue ethics "do not provide a way to act as rules or principles do."[7] Yet, when dealing with conflicting rules or obligations, motive and character may facilitate the decision regarding the most morally appropriate course of action.

In the clinical context, a vast array of skills, a professional code of conduct and situation-specific know-how are part of the everyday professional life of the registered nurse. Therefore, rather than virtue ethics being "weak" because it requires "skills of perception and articulation . . . situation-specific 'know-how,'"[8] it is very useful as an appropriate theory for practice. Thus, virtue theory can contribute significantly to a professional ethic for clinical practice. By nurses reflecting on those virtues, and skills for practice (which in part are the source out of which they derive their identity) they begin to recognize the professional ethic suited for their role.

[5]Wallace J. *Virtues and Vice.* Ithaca: Cornell University Press, 1978.

[6]Beauchamp T. & Childress J. *Principles of Biomedical Ethics,* 4th ed. New York: Oxford University Press, 1994.

[7]Louden R. On some vices of virtue ethics. *American Philosophical Quarterly* 1984; 21:227–236.

[8]Ibid.

An additional criticism of virtue theory claims that the "best person can make the wrong choices."[9] It is questionable that moral mistakes are unique to virtue theory alone. As has been made clear, principled action fails to guarantee the most morally praiseworthy action. Support for this counter to the criticism is lent by MacIntyre:

> when men and women identify . . . too completely with the cause of some universal principle, they usually behave worse than they would otherwise do.[10]

Louden identifies a further weakness of virtues with criticism of the emphasis on character which by nature is subject to change over time. Character change is perceived as worrisome because it is implied that it causes a failure to be morally consistent. However, moral development is an expected dimension of human change as articulated by Kohlberg.[11] The complexity of relationships—considered fundamental to the nurses in Tuckett's study[12]—and associated dilemmas, require fewer moral rules that are too general and simplistic and more of an ethical theory sensitive to the real life experience. Hence, it is virtues or at least "principled virtues" (benevolence and nonmaleficence as compassion, empathy as descriptors of care) that are capable of being viewed as "embodying an holistic response in some range of moral considerations."[13]

In summary, an attempt has been made to defend virtue theory as appropriate to nursing practice. The next section directs the reader to consider the nature of the aforementioned principled virtues in the context of the story of the Good Samaritan[14] as appropriately reflecting care within nursing practice.

[9]Louden, Beauchamp & Childress, op. cit.
[10]MacIntyre A. After virtue: Tradition and the virtues. In: MacIntyre A (ed.). *After Virtue: A Study in Moral Theory.* Notre Dame, IN: University of Notre Dame Press, 1981; 181–203.
[11]Kohlberg L. *Essays on Moral Development: The Philosophy of Moral Development.* San Francisco: Harper and Row, 1981.
[12]Tuckett A. The phenomenon of lying in nursing practice: A case study. MA Thesis. Queensland University of Technology, Brisbane, 1997.
[13]Trianosky, op. cit.
[14]McAllister M. & Ryan M. The Good Samaritan: A revitalised narrative for nursing. *Australian Journal of Holistic Nursing* 1996; 3:12–17.

Nursing as Caring

Kyle observed that nurses can be expected to describe themselves as caring.[15] Caring has been extensively analysed and broadly described within the nursing literature. Some recognize caring as the central core for all that is nursing or the focus construct of contemporary nursing. Others have concluded that caring is elusive and defies a consensus definition. However, describing the nature of caring, if it is dependent upon the context in which it takes place, becomes problematic when no two caring contexts are ever similar.

While there is extensive research into care/caring, the vastness of this research and the associated analysis of it are not fully reported here. A well-recognized story acts as the initial point for an examination of what nurses do. Thus, a reflection on the parable of the Good Samaritan is helpful.

The Samaritan does not respond to the situation in a detached way, as if indifferent to the suffering of the other person, but becomes engaged in the reality of the beaten and bleeding traveler. The Samaritan's response is "a way of being in the world" that steps beyond the boundaries of rules or principle-guided action. This being in the world, which is indicative of caring, has been described as a human trait and part of human nature which is essential to humanity's existence.[16] A commonly cited construct of care, exemplified by this response, is compassion.[17]

In the story of the Good Samaritan, it must be acknowledged that the holy men fail to respond in any way that respects the traveler's presence. They abandon the traveler, leaving him physically and emotionally exposed. The holy men do not care. They treat the traveler as an object rather than as a fellow human being. It is the Samaritan who responds as "other regarding," who promotes "human flourishing of [the] other [rather than

[15]Kyle T. The concept of caring: A review of literature. *Journal of Advanced Nursing* 1995; 21:506–514.
[16]Leininger M. Transcultural care diversity and universality: A theory of nursing. *Nursing Health Care* 1985; 6:209–212.
[17]Fry S. The ethic of caring: Can it survive nursing? *Nursing Outlook* 1988; 36:48. Brody J. Virtue ethics: Caring and nursing. *Scholastic Inquiry in Nursing Practice* 1988; 2:87–95. Wolf Z. The caring concept and nursing identified caring behaviours. *Topics in Clinical Nursing* 1986; 84–93.

his] own welfare." Caring in this sense, which respects another person fully, means appreciating other people in such a way to avoid reducing them to a moral object status. Here the Good Samaritan demonstrates caring as a moral imperative or idea.

The beaten traveler is cared for by the "deeply moved" Samaritan who attends to the traveler's physical wounds and pain at the roadside but who also takes the traveler into the protection of a nearby inn. The caring exhibited by the Samaritan comes out of the "emotional involvement with or an empathetic feeling for" the traveler's experience.[18] The deeply moved Samaritan responds by feeling concerned and having "an oversight with a view to protection." Hence, caring becomes identifiable as an act which is inclusive of a compassionate and empathetic "way of being" that strives to protect the other because of deep concern for that other's threatened personhood.

How does this analysis contribute to appreciating what nurses do in practice? In practice, nurses ought to be like the Good Samaritan. It is not the holy men as strict law followers but the Samaritan who is virtuous—that is, exhibits excellence in a chosen practice.

Caring and the Virtues

It is necessary to clarify my perception about virtues. Virtues can be "defined" in (at least) two ways. Thus, the virtues are discussed as either aligned with principles or by reference to a "virtue-orientated" theory of virtues. Virtues are recognized here as being broadly, but not simply, correlates of principles. If virtues are taken as simply aligned with principles this would fail to appreciate a central assumption of the present paper which is that virtues provide those human strengths required when disputes over principles and rules arise.

The holy men in the parable of the Good Samaritan concern themselves with the external goods of policy and status. In subordinating themselves to the external goods they care less. However, the Samaritan recognizes what is due to a fellow human being and takes action to alleviate another's suffering. It is the Samaritan's caring response that is proposed as useful to nursing practice. It is clear that the caring of the Good Samaritan type is founded on compassion. Following May,[19] it may be claimed that compassion is an intensive form of benevolence (to do good) and its companion, non-maleficence (do no harm).

Tripartite Ethical Practice

As previously stated, the fact that an action is right is not enough for it to be the most morally praiseworthy. On the other hand, neither motivation nor character ensure the most morally appropriate action. An agent may act in a properly motivated way but act in a less than morally appropriate manner. This same agent, nevertheless, while making a mistake, is likely to be more readily tolerated than the rule follower who abandons the most admirable course because of a rigid adherence to rules. One way of expressing this distinction is that an agent operating from an ethic of virtue seeks the mean between the extremes, the fitting response and settles upon an approach through reason. The virtuous strive for reasonableness rather than exactness.

What this means is that within practice, moral virtues direct an agent to the right ends and practical wisdom and contemplation guide the agent to the right means. This analysis approximates Aristotle's

> mean . . . being determined by such a rule or principle as would take shape in the mind of a man [sic] of practical wisdom.[20]

Herein, virtues and principles are able to coexist, particularly as the latter assists with the justification of an act while the former ensures a disposition toward the most morally praiseworthy. Support for the application of a tripartite ethical practice can be found in the analogy of the judicial system and reflection on moral integrity.

Within the judicial system laws and people exist to ensure that sound judgments might be made.

[18]Morse J, Solberg S, Neander W, Bottorf J & Johnson J. Concepts of caring and caring as a concept. *Advanced Nursing Science* 1990; 13:1–14.

[19]May W. The virtues in a professional setting. In: Fulford F, Gillett G & Soskice J (eds). *Medicine and Moral Reasoning*. Cambridge: Cambridge University Press, 1994; 75–90.

[20]Thomson J. Aristotle: The moral virtues. In: Sommers C & Sommers F (eds). *Vice and Virtue in Everyday Life*. New York: Harcourt Brace College Publishers, 1993; 215–226.

Hence principles or laws of the judiciary, like the application of act-moral theory, depend on the sound character and judgment of people. Thus, it is within a context of virtue ethics that the act theories previously described can be acknowledged. Additionally, the concept of moral integrity rightfully acts as the linchpin that keeps the spoked wheel of virtue, utilitarianism and deontology evenly aligned and balanced.

A definition of moral integrity includes terms about an agent's sound, reliable and whole moral character (i.e., a deep sense of self). Additionally, moral integrity infers "fidelity in adherence to moral norms."[21] Hence, what is proposed by this tripartite ethical approach inclusive of moral integrity is an ethic of being good and performing right actions within a virtuous disposition of caring.

This emphasis can be contextualized by adapting Rawnsley who tells the story of a 48-year-old woman who is in the final stages of dying from metastatic cancer.[22] The ill woman's chemotherapy and radiation treatment had failed, resulting in the cancer invading the bones and brain. The story concludes:

> Angela slipped in and out of consciousness. On the last morning of her life, Angela opened her almost sightless eyes and struggled to speak. "Susan [Registered Nurse] are you here?" Susan took her hand. "Yes, I'm here," she answered. A few minutes later Angela asked, "Susan, am I dead yet?" Susan moved to the bed and stroked her arm. "Angela," she said, "you are here with me." Angela stirred again. "Are we dead together, Sue?" There was a brief hesitation, then she spoke softly, "Yes, Angela, we are together."

Both the story of the Good Samaritan and Rawnsley's adapted story exemplify the type of person a nurse ought to be as central to an appraisal of morally acceptable action. While an adherence to rules resulted in the holy men responding in a less than compassionate way so too an adherence to honest disclosure in Rawnsley's story would have resulted in a less than morally praiseworthy response.

[21]Beauchamp & Childress, op. cit.
[22]Singer P. *Practical Ethics*, 2nd ed. Cambridge: Cambridge University Press, 1993.

Discussion Questions

1. According to Tuckett, what does the moral theory of virtue ethics suggest for the practice of nursing? To what extent, if any, is a feminist ethics approach relevant to Tuckett's discussion?
2. Explain Tuckett's aim in describing the story of the Good Samaritan. How well do you think the connection to virtue ethics is established?
3. In general, do you think this basic approach to ethics in the nursing profession can be used successfully by nurses? Why or why not? Use examples of ethical decisions nurses face.

A Dilemma of Caring: Ethical Analysis and Justification of the Nurse Refusing Assignment

LUCIE FERRELL

Introduction and Overview

Nursing is a profession of caring for others. It is precisely because of this caring that it matters to the nurse whether or not patients receive safe, competent nursing care and it is because of this caring that the nurse feels compelled to undertake personal risk for the good of the patient. It is this caring that provides the essential basis of most moral dilemmas in nursing as well as for the nursing commitment to patients. If the nurse did not perceive caring to be a primary ethical and professional value, moral issues could be classified as practical dilemmas or merely problems to be solved. It is through caring that the issue of refusing assignment becomes a moral dilemma.

The purpose of this paper is to analyze the moral dilemma of the nurse confronted with the choice of refusing assignment and to develop the ethical argument upon which the justification for such refusal will rest. I seek to identify the moral dividing line at which it ceases to be the nurse's duty to undergo personal risk for the benefit (real or supposed) of the patient. Establishing that one has a right to a particular action is insufficient to resolve a moral dilemma. If, in exercising that right, one places oneself and/or others at significant risk of harm, then that action will be judged as wrong unless it can be justified through ethical principles and argument. Therefore, no matter what the rhetoric about the nurse's right to refuse assignment, unless such refusal is ethically compelling, it is not a choice open to the nurse whose primary duty is to care for patients. If it is not an ethical option, it would have to be interpreted as abandonment of the patient, a practice disallowed by ethical and professional standards. It would be contrary to acting in the best interests of the patient, thus violating the principle of nonmaleficience or "do no harm," while also seeming to be self-serving on the part of the nurse.

Traditionally, refusing assignment when it involved understaffing or inappropriate/unsafe staffing was specifically viewed as unethical; refusal was allowed only on grounds of grave physical harm to the nurse or on religious-moral grounds when objections were made known prior to the situation arising. However, in the contemporary healthcare environment of fiscal constraints, increased technology, high patient acuity, and malpractice litigation, the issue of refusing assignment warrants a reexamination. Clearly, the nurse may not refuse assignment based on medical diagnosis, patient characteristics, socioeconomic status, or personal preference. But situations such as mandatory overtime, temporary staffing, "floating" to an unfamiliar clinical area, and/or assignment to an unsafe number of patients place the nurse at risk for a variety of harmful consequences.

The Question

The question under consideration is: On what grounds is it morally justifiable for a nurse to refuse assignment; how much and what kind of personal risk must the nurse assume in order to meet the professional responsibility, moral obligation, and legal duty to provide care? What ensues is a philosophical inquiry addressing this moral dilemma utilizing the organizing framework of The Dimensions of Professional Nursing Practice. Assuming that the nurse has the right to refuse assignment, it is only through ethical justification that this right may be exercised and moral and professional integrity maintained. Ethical justification does not necessarily protect the nurse from legal or economic consequences of the decision but it does allow for a decision that will uphold the

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professional commitment and moral obligations of a health care professional.

Refusing Assignment as a Moral Dilemma

A moral dilemma is manifested in three ways. First, it is a situation of unavoidable choices; choosing is inescapable and must occur. Moreover, the person must act on that choice. The second element is that the choices are mutually exclusive. The agent cannot do both because one choice precludes the other; in choosing one alternative, the agent is prohibited from choosing and acting on the other. The third criterion is that the situation is a momentous one and the choices are significant. It is not a trivial choice in small matters; the situation, the choices, and the outcome are of grave importance.

From this discussion it is clear that the nurse who is given an unsafe or unreasonable assignment and who must then choose between the two unsatisfactory alternatives of accepting or refusing that assignment experiences a moral dilemma. This is truly a momentous situation and clear moral principles apply and offer justification for the two competing alternatives. Neither set of reasons, however, is obviously dominant and both alternatives will result in undesirable as well as desirable consequences. The nurse is, of course, precluded from choosing both and the choice is significant. She must choose between accepting and refusing assignment and then must act on that choice. She cannot not act.

To illustrate the moral dilemma of refusing assignment, the following scenario is offered:

> The staff nurse reporting to the pediatric intensive care unit (PICU) at 7:00 A.M. is told that, because the other nurse scheduled had to be "floated" to another unit, the nurse will alone be responsible for the five acutely ill PICU patients, two of whom are on ventilators. The supervisor stated she would try to get additional help but the nurse "must simply do the best she can." While the nurse is giving care to a patient with tracheotomy, a second patient develops increased intracranial pressure that goes undetected for at least twenty minutes. As a result, that child suffers permanent brain damage. Additional help never does arrive and the nurse works 16 hours without meals and without a break. Later, the parents of the second child sue the nurse for malpractice and the State Board of Nursing places a disciplinary letter in the nurse's file citing "poor judgement" on the part of the nurse.

The Customary Ethic

Not every assignment situation is a moral dilemma. If the nurse can reasonably accept the assignment or if the patient is placed at no risk through refusal or acceptance, then there is no moral dilemma and the right choice is clear. In a situation deemed unsafe or unreasonable or in which the nurse and/or patients are put at risk, however, the possibility exists. Because there is the likelihood of harm to the patient in this kind of assignment situation and because there is the additional potential for harmful consequences to the nurse, there is a decision to be made. Moreover, in considering the moral agent, the nurse, these potential consequences to her are significant and are of legitimate concern. Therefore, although not previously regarded as such, refusing assignment is a genuine option and the choosing between the two options, accepting and refusing, is the moral dilemma. One of the problems with the historical presumption of acceptance is that the meaning of that acceptance was probably not pondered by anyone involved in the situation. However, acceptance is the crux of the dilemma and, in order to discuss refusing assignment, it is necessary to examine the meaning of accepting. To do so, it is helpful to utilize the descriptive definitions developed by the American Nurses Association Task Force charged with exploring this issue. These provide the point of reference throughout this paper:

> Accept Assignment: I am able to and will provide safe competent nursing care at the generally accepted standard of practice in this patient situation and accept professional, legal, and ethical accountability accordingly.
>
> Refuse Assignment: In my judgement, I cannot provide safe competent nursing care in this patient situation. Therefore, while recognizing the risks involved, I do not accept this assignment. (ANA 1990, p. 1)

If the nurse cannot meet the criteria established in the definition of accepting assignment, there is a strong likelihood that she is confronted with a

moral dilemma; ethical analysis and decision-making is required.

The customary ethic, the presumption of acceptance, was often based on the concepts of duty and obligation: the belief that "any nurse is better than no nurse at all" and that the nurse would simply do as well as possible under difficult circumstances. Pure altruism was the prevailing value and refusal was viewed as abandoning one's patients. However, given today's environment, the question arises as to whether this customary approach serves anyone well—patients, society, or the profession of nursing.

Nursing Ethics

"The three features of professionalism—a claim to competence, a socially valued goal, and autonomy—naturally lead professionals to a special concern with ethics" (Jameton, 1984, p. 22). The profession of nursing, and hence its ethics, has as the central concept the relationship between the patient and the nurse, the very nature of which is moral. What's more, it's the ideal of service "that, in part, distinguishes nursing ethics from medical ethics" (Fowler, 1990, p. 28). According to Fowler, this service ideal as the central moral core of nursing ethics currently is expressed in the notions of caring and advocacy as metaphors for nursing. These are the ideals that define the nurse-patient relationship. Quinn and Smith (1987) further state that ethical values are all expressions of what is owed patients as well as expressions of the professional self. Thus, nursing ethics is concerned with two elements: what the nurse ought to BE and what the nurse ought to DO.

THE NURSING COMMITMENT

A specific aspect of the professions that sets them apart from other occupations is the idea of commitment: commitment to the people of the society in which the professions exist as well as to the values on which the profession is based. "In choosing the profession, one assumes the responsibility consistent with being a professional. One chooses to adopt the values, methodology, and 'way of life' of the profession. This is a free and unencumbered choice of occupation, a conscious decision to make a commitment to practice a profession in return for the privileges granted to those who practice" (Muyskens, 1990, p. 137). Ozar (1987) writes: "Being a member of the nursing profession requires a commitment that the individual freely makes to the community at large. This is a commitment not just to think and act wisely but to do so in accord with the specific values and principles of the nursing profession" (p. 155). In discussing this further, he describes this commitment much like a promise or a contract to act in certain ways so as to benefit another person or group. He cautions that the act of professional commitment is unlike making a promise or a contract, however, "because of the particular character of the professional-client relationship" (p. 158).

MORAL AUTONOMY IN NURSING

"Autonomy, put simply, is control over one's own life" (Quinn and Smith, 1987, p. 31). Therefore, moral autonomy in nursing may be viewed as control over one's moral life in the practice of nursing. Engel (1970) defines work-related autonomy for the professional as "freedom to practice his profession in accordance with his training" (p. 13) and states that this autonomy is important to the professional because it affects the quality of the service he provides. The loss of work-related autonomy might reduce the quality of his care.

"Traditionally, nurses have been discouraged from developing and acting on their own ethical judgements" (Benjamin and Curtis, 1987, p. 394). Recognizing this, the authors acknowledge that being ethically autonomous can be difficult and even "personally hazardous" for the nurse because the traditional conception of nurses as obedient and subservient is deeply embedded in both the healthcare system and the general public as well. These authors define the ethically autonomous nurse as one who can "within limits exercise independent thought and judgement about what she ought to do and then act accordingly. As a result, she will be morally responsible for what she does and for the foreseeable consequences" (p. 398). Criteria for autonomy are two: that the action be free and that it is based on rational deliberation and moral reflection. Again, ethical autonomy doesn't necessarily guarantee the best or right decision but it does ensure that the decision-maker is and ought to be respected as a morally responsible person.

Benjamin and Curtis (1987) argue that moral autonomy "provides the foundation for moral

responsibility . . . is part of what it means to be, and be respected as, a person" (p. 40). In support of this position they state that the nurse is first a person with goals, principles, and ideals: a self-determining individual. To perceive of a nurse as anything less than ethically autonomous is, therefore, "demeaning and incompatible with what a nurse is" (p. 403), a self-determining person. Further, nurses who carefully think for themselves about ethical and other matters are more likely to be sensitive to the complex personal, emotional, and physical needs of their patients. This sensitivity to patient needs would, of course, enhance the quality of patient care, thus contributing to excellent practice, the moral imperative of nursing.

In summary, ethics assumes the personal accountability of that person for both individual actions and the consequences of those actions. Professional ethics presumes no less. Based on the professional commitment made to the society, the nurse is presumed capable of self-determination as a healthcare professional and is held accountable for the moral practice of nursing. As a professional, the nurse is expected to have thought about this commitment and the moral obligations this entails. The nurse is expected to use critical thinking and moral reasoning when making nursing judgements and to uphold the professional ethical standard of excellence.

Analysis of the Dilemma: The Dimensions of Professional Nursing Practice

In his discussion of a moral dilemma, Ladd (1983) describes this as an "unavoidable situation in which one is forced to choose between performing one obligation rather than another, or to choose between evils, rights or wrongs, duties, and so on" (p. 144). So it is with the moral dilemma of refusing assignment; both choices contain obligations and both choices place powerful and legitimate claims upon the nurse, the decisionmaker. Further, both choices, accepting and refusing, carry significant risk of harmful consequences for both the patient and the nurse. Consideration of these potential consequences to the nurse leads to the identification of The Dimensions of Professional Nursing Practice, which serves as the framework which facilitates this analysis. These dimensions are: The Ethical Dimension; The Socio-legal Dimension; The Legal-regulatory Dimension; The Economic Dimension; and The Personal Dimension. It is the role of the nurse within each which serves as the unit of analysis in the deliberative process of ethical analysis.

THE ETHICAL DIMENSION: THE NURSE AS MORAL AGENT

Despite the multidimensional character of this moral dilemma, the decision to accept or refuse assignment is ultimately an ethical one. The profession of nursing exists to provide care to patients and excellent care is the "primary moral imperative" of nursing practice; good, defined as patient health and well-being, is the goal of that care. It follows that there is the potential to harm patients as well, as a consequence of inadequate, substandard, or unsafe nursing care or through error, either directly or indirectly, knowingly or unintentionally. Because of this potential for causing harm as well as good, the health care environment is viewed as moral universe and nursing as a moral endeavor. In this sense the nurse is a moral agent, responsible and accountable for her practice: her judgements, her actions and the consequences of these. When people become "patient" they place themselves in the care of nurses who, they trust, will act morally and with the best interests of patients as their primary concern.

Relative to moral agency, Engelhardt (1986) identifies nurses as "in between" persons. Nurses are caught in-between the traditional authority of the physician, the emerging rights of the patient, and the power of hospital bureaucrats. This makes it difficult for nurses to make decisions. Yarling and McElmurry (1986) further argue that nurses are not free to act as they feel morally compelled to act because of institutional constraints; nurses are not free to exercise their commitment to patients. The authors contend that nurses lack sufficient autonomy to be moral agents. Bishop and Scudder (1990) refute this with the statement, "The in-between place of the nurse does not free her from the responsibility of making moral decisions; instead, it sets the context in which these decisions must be made" (p. 137).

The moral agency of the nurse is consistent with the statement by Taylor (1975): "A moral agent is any being who is *capable* of thinking,

deciding, and acting in accordance with moral standards and rules . . . he need not be morally perfect. But he must have the capacity to judge himself on the basis of a moral standard and to use it as a guide to his choice and conduct" (p. 6). In the current analysis, the nurse is viewed as a moral agent in that she possesses individual ability to affect the good and to cause harm to the patient and she holds personal moral accountability for her practice. The nurse as moral agent is required to uphold excellent practice as the standard.

THE SOCIO-LEGAL DIMENSION: THE NURSE AS AUTONOMOUS PROFESSIONAL

The nature of the professions is that they derive their meaning from societal values; the mandate of the profession is to safeguard, protect, and promote those values. This constitutes an implicit social contract of trust between society and the professionals. In exchange for considerable autonomy, the professionals are expected to act responsibly, always mindful of that public trust. This implicit contract is made explicit and given formal sanction in the legal system through Tort Liability. Even though, traditionally, nurses have been protected from liability, there are numerous instances in which the nurse has been held legally accountable. Indeed, the increasing professional stature of nurses is reflected in an increase in the number of nurses who are named in malpractice litigation, often as the sole defendant.

"One of the chronic and most critical issues a nurse faces is the extent of his or her legal responsibility when assigned to an understaffed hospital unit" (Politis, 1983, p. 109). In assignment situations of questionable safety, the nurse is charged with legal as well as moral accountability for her actions. In considering the moral dilemma of accepting or refusing an assignment, the nurse is faced with legal consequences of either choice. If she accepts the assignment, as an autonomous professional she is held legally accountable for her practice. "Nurses who are floated to units where they ordinarily don't work aren't protected by a lower standard of care. They are held to the same standard of care that applies to any R.N. on that unit" (Maher, 1989, p. 34). In an understaffed unit, the effect on patient care can range from reducing the quality of care to actually jeopardizing patient safety. And yet, the nurse who is held accountable for her practice and liable for failure to maintain professional and legal standards of care has no control over administrative staffing decisions.

In discussing the nurse most likely to get sued, Sharpe (1999) identifies the nurse who appears oblivious or unresponsive to patient needs as most at risk. However, he states further that "the practitioner who attempts to care too much is also at risk" (p. 42). He describes the conscientious, dedicated nurse who, however well-intentioned, oversteps the limits of her clinical skills, licensing, and professional knowledge and thereby places both herself and the patient in jeopardy. "The nurse who accepts an assignment, or has an assignment imposed on him or her for which he or she is not prepared by education, training, or experience, may be inviting a malpractice lawsuit" (Sharpe, 1999, p. 42). In the legal system, the nurse is regarded as an autonomous professional.

THE LEGAL-REGULATORY DIMENSION: THE NURSE AS LICENSED PRACTITIONER

Nursing is a health care occupation which has been granted the privilege and consequent duties of licensure. "Licensure can be defined as the process by which a legal authority grants permission to a qualified individual or entity to perform certain activities that are declared to be illegal without a license" (Rhodes and Miller, 1984, p. 21). What this means in practical terms is that nursing is subject to governmental regulation and the individual nurse is held legally accountable for practice; should the nurse fail to meet established legal standards of maintaining such licensure, there will be consequences imposed. Regulatory agencies tend to apply a minimum standard, below which a nurse may not practice, no matter what the circumstances. Such agencies hold the nurse accountable for inadequate or unsafe nursing care, even though staffing is beyond the nurse's control. Further, while malpractice requires that harm has occurred as a consequence, this is not the case for a nurse to be subject to disciplinary action. It must only be demonstrated that the nurse's practice was substandard.

THE ECONOMIC DIMENSION: THE NURSE AS EMPLOYEE

Most nurses are employees and thus dependent upon an institution as the means to practice their profession. This is inherently a situation of conflict because, as a professional, the nurse is autonomous but, as an employee, she is not. As a professional, the nurse is accountable to a specific ethical and professional standard of practice; as an employee, however, she experiences employer control in that she is subject to employer standards, rules and regulations, economic concerns, and fiscal constraints. These two diverse sets of standards and interests are not necessarily mutually exclusive, but, especially in the current healthcare environment, are often at cross-purposes, viewed as incongruent and even incompatible with professional status. It is this situation that often, as a result, puts the nurse in the middle. Whether between patient and employer, between ethical and economic, between legal and questionable, between role as professional nurse and role as employee, the nurse often finds herself caught "in between" conflicting values or standards. The issue of accepting or refusing assignment is a classic example of this situation in which a nurse employee finds herself having to choose between two mutually exclusive actions.

"Hospitals are dizzyingly complex. Nurses thus experience a variety of responsibilities and allegiances which create opportunities for conflict. . . . According to the best health care practice, the nurse's primary responsibility is to the patient, but nurses also have important responsibilities to the hospital. Although a hospital's main duty is, in principle, patient care, it may be poorly organized for it. . . . Thus, conflicts between duties to patient and duties to employer arise for nurses in hospital settings" (Jameton, 1984, p. 10). Institutions such as hospitals exist for a purpose and are governed by rules designed to ensure that the institution operates to achieve its stated goal. Further, individuals within institutions have obligations which exist because they are members of that institution. Within a hospital which, by definition, has moral obligations to society and to patients, there are rules designed to assist the hospital in meeting these moral obligations. Such rules carry with them the weight of the moral imperative and, therefore, individual employees have the moral obligation to follow them. "Such obligations are the result of the individual's agreement to participate in the institution" (Purtilo and Cassel, 1981, p. 171). In this sense, a minor injustice to an employee may be justified by a greater moral imperative. This is often interpreted as "the obligation to help those in need supersedes the moral obligations of the institution to provide fair employment practices" (Purtilo and Cassel, 1981, p. 171). Translated into law, it becomes the employer's legal right to control employees and to conduct business. The reality is that, unless a nurse employee is protected by a specific contract prohibiting the practice, she can be terminated by her employer should she refuse an assignment.

Either accepting or refusing assignment places the nurse at economic risk. If she accepts the assignment which she judges to be unsafe or unreasonable, she is nonetheless held to the same legal and professional standard of care as always. Should she make an error that causes harm to the patient, she can be sued and she can be disciplined by the regulatory agency. This discipline may include the temporary or permanent loss of her license to practice which would mean the loss of her means to earn a living. This, obviously, would constitute a severe economic loss to the nurse.

A professional has been described as one who is bound by values and standards other than those of his or her employing organization and yet, this very autonomy is in question. The fact is, "Nurses are employees of the hospital; if they are involved in a conflict they realistically must face the possibility of losing their jobs. The hospital loses an employee but no significant source of revenue" (Quinn and Smith, 1987, p. 83). In a very real sense, it is the nurse, of all those involved in this dilemma, who has the most to lose and, therefore, the most at risk.

THE PERSONAL DIMENSION: THE NURSE AS PERSON

The personal dimension may be the most basic aspect of this dilemma. The consideration of the person who is the nurse lends a certain poignancy to the situation demanding that the nurse make a choice that will, in all likelihood, compromise her integrity in some way. In a situation of acute staffing need, it becomes all too easy for the indi-

vidual nurse to be considered as simply a commodity, an interchangeable service provider.

Englehardt (1986) writes about an "intrinsic tragedy to morality" (p. 100). It would seem that the nurse who must choose between two such self-compromising alternatives as accepting or refusing an unsafe or unreasonable assignment, is truly a tragic figure. What is more, the tragedy is not in the choice but in the choosing. The very integrity of this person is threatened: professional, moral, and personal integrity. It is self-evident that a person who is required to live and work with such risk and conflict would experience significant personal consequences. A personal compromise of moral and professional integrity would arguably take its emotional and psychological toll on any individual. It is likely that this toll could be even greater on a nurse because of the kind of professional service that is provided by nursing and the nature of the human need to which nursing responds. It is this nurse-person who is arguably the most at risk for it is she who faces the moral dilemma of choosing between options that could each cause her personal harm. It is she who, in her adopted role of nurse, is expected to practice nursing with constant adherence to that most basic ethical principle of respect for persons. As a health care provider, this nurse must practice with moral integrity and professional commitment, maintaining and safeguarding her own well-being as well as that of patients. As nurse, this person is expected to care about her patients, her co-workers, and the work of her employing institution. She is expected to act "with courage" when confronting injustice (Purtilo and Cassel, 1981, p. 35); with integrity where encountering potential harm to patients; with compassion in her daily work of nursing; with a constant willingness to place her patient's welfare as the highest priority; and with "excellent practice" as her moral obligation (Bishop and Scudder, 1990, p. 113).

Conclusion

Based on this analysis, it is concluded that, because of the significant risk of harmful consequences to the nurse inherent in this moral dilemma, the nurse must be considered as a factor within this dilemma and as an integral part of the decision-making process. Further, because of such significant personal risk, the individual nurse is the only person who can make the decision of accepting or refusing an unsafe or inappropriate assignment. Despite the legality, it is morally wrong for the nurse to be mandated, threatened, persuaded, or coerced into acceptance. The question remains: How can the nurse maintain the personal, professional, and moral integrity as well as reconcile her conflicting moral, legal and professional obligations? In the words of Ozar (1987), "The most crucial question for the decision-maker in a situation of profound ethical conflict, then, is to try to determine which of the relevant values and principles are indeed the most basic and then whether they are basic enough that they must take precedence over the obligations implied by professional commitment" (p. 175).

Justification: Utilitarian Ethics

The consequentialist perspective provides ethics theory that is of primary relevance in addressing the moral dilemma of refusing assignment because it is this approach that enables one to account for and incorporate the significant risk of harmful consequences to the nurse of either alternative. It is this risk of harmful consequences to the decision-maker that makes this a unique moral dilemma for the nurse and it is utilitarian ethics theory that best provides a framework for ethical justification of refusal. It is the consequences to all those concerned or involved that are the most severe aspect of this moral dilemma. The greatest potential for harm is in the consequences of the nurse's action and ethical justification is adequate only if these are considered.

Utilitarian ethics focuses on outcomes as the critical element in analysis and justification of moral action; it considers the consequences of human acts as relevant in judging those acts as moral or not, as right or wrong. From this perspective no action is good or bad in itself but, rather, it is judged good or bad in relation to the good or bad consequences it brings about. What's more, analysis incorporating the consequences to all those concerned is mandated. According to utilitarian ethics theory:

> What is morally good *always* consists of surveying the possible courses of action open to us, determining their effects on the welfare of *everyone* who will be affected by them, and

then choosing the course of action that will do the most good coupled with the least harm for as many people as possible. (Quinn and Smith, 1987, p. 16)

The goal of ethical decision-making utilizing utilitarian ethics theory is to maximize the benefit and minimize the harm to all affected that result from the decision. This is accomplished through identifying the probable consequences, both good and bad, and then considering the intrinsic value or intrinsic disvalue of each. Ethical justification of the nurse refusing assignment is based on consideration of the probable consequences, good and bad, of accepting assignment to all those affected by the decision. Consideration is then given to the probable consequences of refusing assignment using the same factors. Based on this analysis, the judgement is then made that accepting assignment may be the morally wrong action because it results in greater harm than good to all those affected by the decision. Therefore, refusing assignment would be the morally right thing to do. It must be remembered that both accepting and refusing assignment will have harmful consequences. Only one choice is possible, however, and that choice is morally right which results in the most good for the most people, including the moral agent, and the least harm for all affected, again, including the moral agent. Refusal of assignment is justified when it is action that is likely to result in the most benefit and least harm to all persons affected by the decision, including the nurse.

Illustration and Discussion

To illustrate the ethical analysis and justification process, this discussion will focus on the scenario presented earlier to illustrate this moral dilemma in which the staff nurse in the pediatric intensive care unit is mandated to care for five acutely ill children. Because the scenario involves staffing in a specialty unit (PICU), it is helpful to digress here and describe how this environment affects the decision-making process. An intensive care unit (ICU) by definition is a clinical specialty area in which patients are critically ill and are at high risk for medical crises and emergencies. Nursing care is intense and requires specialized clinical knowledge and technical skills. These include clinical assessment and decision-making skills; knowledge of pathophysiology and medical management; knowledge of and skill with technical procedures; and knowledge of and skill in using specialized monitoring equipment as well as interpretation of data and appropriate intervention based on patient data obtained from such equipment.

In this scenario in which the nurse is assigned to provide care to five PICU patients, both the patients and the nurse are placed at high risk for harmful consequences through the nurse's acceptance of the assignment. The patients are quite likely to be harmed by poor quality, unsafe nursing care because no nurse, despite her experience and/or expertise, can give even minimal care, let alone "excellent care," to five PICU patients. It is a physical and professional impossibility. Indeed, patients did actually suffer harmful consequences, as illustrated by the child who sustained permanent brain damage because the nurse was unable to respond to the medical crisis. Increased intracranial pressure is an emergency situation which demands immediate attention and response by the nurse and then prompt medical intervention as well. The nurse was unable to monitor, to assess, or to intervene and, as a direct consequence, this patient and this family sustained significant permanent harm. In situations such as these in which the nurse clearly lacks the clinical ability to give safe (minimal), let alone excellent, nursing care, intrinsic harm to the nurse as a consequence of her acceptance is probable. As a moral agent, excellent care is impossible and so her moral integrity, an intrinsic value, is compromised. As an autonomous professional, she is at high risk for malpractice litigation from both intentional (in that she should have known) and unintentional negligence. The nurse's license, both an intrinsic and an instrumental value, is jeopardized through her acceptance because she will not meet the legal standard of care. Again, this harmful potential consequence to the nurse became a reality in which a disciplinary letter was placed in her license file by the state Board of Nursing, thus permanently becoming part of her professional licensure records, available to her actual and potential employers for the duration of her career. Furthermore, because the letter cites "poor judgement" as the problem, this is especially harmful to this nurse because nursing judgement is of prime

importance in professional nursing practice. This nurse will continue to be asked to explain this citation of "poor judgement" by even the least astute of employers. And, because of the actual and real consequences of the nurse's judgement and professional decisions, this is as it should be. However, this will directly affect her employment potential and her professional relationship with any and all future employers.

A further aspect of harm to the nurse is the malpractice suit which was brought against her. As stated earlier, the nurse is legally held to the professional accountability standard of practice. A nurse who has been cited for "poor judgement" by the Board of Nursing would be hard-pressed to convince a jury that she should not be held legally liable for the harm suffered by this patient and this family. As a professional responsible for her judgements and her actions she would find it almost impossible to defend her judgement in this case. Neither would she likely find expert witnesses willing to testify that her accepting this assignment was what the reasonably prudent nurse would do, despite the extenuating circumstances of supervisor coercion. Despite the obvious coercion, this nurse is legally accountable for her practice.

In this situation, there are also potential harmful consequences to the hospital as a result of her acceptance. Should a patient be harmed by the nurse's error or negligence, the hospital has joint liability in its capacity as employer. The hospital would also be held legally accountable through the principle of corporate liability for failing to provide adequate and qualified nursing staff, thus failing to meet its legal obligations to patients. The hospital (as a legal person) hardly demonstrated responsible actions or judgement regarding patient safety and adequacy of staffing. In short, the hospital did not act as a reasonably prudent hospital would act in similar circumstances. Tort liability holds the hospital legally liable for this patient harm.

The only good consequence of accepting this assignment would be for the nurse in that, by accepting, she protects her job. While "work" is often identified as having intrinsic value, good in itself and not just as a means, a specific job is usually thought to have instrumental value, that is, a means by which one achieves a further end: physical and economic survival. May the nurse sacrifice consequences of intrinsic value to all affected for a consequence of instrumental value to her? According to utilitarian theory, no. Refusing assignment in situations in which the nurse lacks clinical ability and/or competency is ethically justified through utilitarian theory. It is only refusal that results in far more benefit than harm to all. It protects the patient from this nurse's substandard nursing care; protects the nurse's personal and moral integrity; protects the nurse's professional autonomy; prevents malpractice litigation for the nurse; protects the nurse's license; and, requires that the hospital find a different and right solution to this staffing problem, one that protects patient safety and well-being and that respects the moral and personal autonomy of the nurse. All of these are consequences that represent the most benefit to all those people affected by the choice and action of the nurse in this situation.

Conclusion

Although the traditional presumption of acceptance is a strong societal and professional value, based at least in part on the nurse's moral and legal duty to patients, automatic acceptance of an unsafe or unreasonable assignment is not in the best interests of anyone involved—the patient, the nurse, or the hospital. In the words of Muyskens (1990), "The overwork and understaffing not only make working conditions less desirable for the nurse; they clearly endanger the patients" (p. 287). In the complexity of today's healthcare environment, the consequences to all those affected by the decision must be considered, relative to harm and to benefit, as a factor in the moral reasoning required in this dilemma. Despite the nurse's moral and legal obligations to provide care, the morally right act may not be to accept the assignment but, rather, to refuse. It is through moral reasoning that the right action can be determined. Because nurses have the obligation to act for the benefit of the patient and not in their own self-interest at the patient's expense, refusal of assignment must be ethically justified. According to utilitarian ethics theory, in situations of unsafe or unreasonable assignment, it is acceptance which may be evaluated as the morally wrong action and refusal the morally right. The decision can be reached only through the intellectual process of

moral reasoning, the ethical analysis and judgement of the action in terms of its consequences. As difficult as it may be, the nurse, having chosen to make the professional commitment, must live with and wrestle with moral dilemmas and, sometimes, unavoidable consequences.

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Discussion Questions

1. Why does Ferrell refer to the situation she describes as a "moral dilemma"?
2. According to Ferrell, do nurses have any ethical obligations beyond those that are explicitly specified by the hospital? What is your view?
3. In the last section of her article, Ferrell uses utilitarian ethics to solve the nursing dilemma. Explain in detail how she does so. Does she succeed? Why or why not?
4. How might feminist moral theory be used to support Ferrell's views? What other moral theory (or theories) might support her views?

Health Care as a Business: The Ethic of Hippocrates Versus the Ethic of Managed Care

MARK H. WAYMACK

THE ETHIC OF HIPPOCRATES is, in an important sense, quite ambiguous. Scholars of the history of medicine or the history of ideas may have certain interpretations—interpretations which generally view the Hippocratic Oath in terms of ancient Greek medicine, particularly of the Pythagorean tradition. The general public in America, however, while being quite unacquainted with the actual text of the Hippocratic Oath, nevertheless has a public conception of that special oath that medical students take as part of the rites of passage from student to physician. That the oath that medical students take might bear only a faint resemblance to the historical Hippocratic document, and that there is no universal uniformity in the words of the oath that different medical schools ask their students to swear, have not prevented there being a popular public conception of the ethic to which physicians are bound. Of the features of that ethic, the one that concerns us here is the notion that when caring for a patient, the physician should have *only* the welfare of that individual patient in mind. The question of *finances* should never be allowed to deter the physician from recommending the most medically appropriate of the alternatives. This loyalty to the individual patient is part of what is seen as the special ethical obligation of the physician as a *professional.*

In recent years, however, the practice of medicine has become more a practice of business than it has in the past. Physicians are engaged in joint ventures; and hospitals are competing with each other for economically profitable physicians and referral networks. But one change in practice that

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has perhaps touched upon Americans most pervasively is the introduction of managed care. The introduction of federal diagnostic-related-groups (DRGs) and, more recently, the enormous and increasing enrollment in both for-profit and not-for-profit health maintenance organizations (HMOs) have sparked a number of discussions concerning the ethical conflict of interest in which such arrangements place physicians.

For convenience's sake, let us take the HMO as an example of managed care. At the heart of the typical, contemporary HMO is the idea of cost containment. The original idea of reducing health care utilization by encouraging health maintenance, though not entirely abandoned, has had only limited success in achieving the control of escalating costs desired by health care premium payers.[1] The far more effective method of cost control has been the control of services. Under fee-for-service insurance, the insured person could see virtually any physician whom he or she wished and be compensated for most any sort of care ordered by the physician. This gives rise to a tendency for physicians to make excessive use of services and does nothing to discourage patients from seeking and receiving unnecessary services. Within the HMO, however, a primary care physician usually must *authorize* the use of special care, including laboratory expenses, any use of health services outside of the normal HMO network, and referrals to specialists either in or outside of the HMO network. This has come to be known as the "gate-keeper" role, or to distinguish it from the term "positive gate-keeper," what Pellegrino and Thomasma call the "negative gate-keeper."[2]

Thus, the HMO keeps expenses down by keeping down the utilization of health care services. The gate-keeper may reduce costs by preventing *over-use* of medical technology. But in some instances, the gate-keeper contains costs by preventing the use of technology that the HMO, though it recognizes as effective, may deem to be *too expensive* to include in its coverage. Ford Motor Company will offer its most popular automobiles with vinyl rather than real leather upholstery. Using real leather as a matter of custom would make the car cost more money than most of its target market audience would be willing to pay. HMOs engage in the same sort of reasoning. For example, HMOs may deem that liver and pancreas transplants are simply too expensive to fund. If they can argue that such care is not included in "basic care" (for all HMOs are required by law to cover for "basic care," just as all cars are required to meet certain minimum safety standards), then the HMO can write its policy such that *the policy does not include such procedures.* Other tactics might include longer waiting lines (encouraging the most cost-efficient use of expensive physician time), and the use of skilled nurses to screen presenting patients before they ever see a physician.

So while the "Mercedes" of health insurance might cover for everything from a liver transplant to liposuction to artfully sculpt one's knees, and do so at the patient's convenience, the "Ford" of health insurance will not offer such non-basic services and may require some patience and forbearance on the part of the patient.

In conclusion, the HMO offers what must be considered, at least in many respects, an intrinsically less desirable product than traditional fee-for-service health insurance. What makes HMOs choiceworthy for many consumers, however, is that in the consumer's judgement the lower costs of HMO insurance (lower premiums and often lower or no costs per visit or procedure) more than balance out the restrictions involved with the service. So just as, when our own resources are not infinite, we may willingly choose the sturdy Ford over the crafted and polished Mercedes with the real leather interior, the compact disc stereo and anti-locking brakes, so we may willingly choose the inexpensive but serviceable HMO over the more generous fee-for-service insurance plan.

How Cost Containment Is Enforced

We have briefly outlined how HMOs can reduce costs through the use of a gate-keeper. Let us

[1]In earlier decades, HMO-type health care plans were actually among the "elite" kinds of health care insurance. Premiums were relatively higher, but the lack of any deductibles or co-pays was attractive and there was little or no rationing. It is only in recent decades with (a) the entrance of several large for-profit firms and (b) in an economic environment where HMO plans have been sold to employers as less expensive alternatives to fee-for-service that the ethical difficulties that we are discussing surfaced in the HMO environment.

[2]Pellegrino and Thomasma, *For the Patient's Good,* New York: Oxford University Press, 1988, pp. 177–180.

explore more closely here how the gate-keeper role functions. The gate-keeper helps to minimize health expenses by preventing unnecessary and/or inappropriate use of health services. This function is often reinforced or supplemented by a "utilization review committee," which reviews the practice patterns of physicians in the HMO group, looking for atypical patterns of practice. Atypical patterns of practice (such as over-use of hospital stays, overuse of diagnostic interventions and drug therapies, or even *improper* use of health services) usually cost the health insurer (and eventually the payer of the premiums) more money in the long run. They can also have, at least in some cases, an adverse effect on the health of the patient. Hence, when atypical patterns are detected, they are examined and if they represent poor practice patterns (rather than the excellent physician who occasionally get sicker patients because of his or her special skills), the physician is instructed in how to change his or her pattern of practice.

Now, physicians may tend to be cautious and conservative in their style of practice. Hence, it can be difficult to get them to change their patterns of practice. HMOs have taken a variety of tactics to encourage changes in practice. One tactic is simply the strongly worded suggestions of a utilization review committee. This tactic, however, may seem to lack much punch. Consequently, some groups have offered physicians financial incentives to bring their style of practice into conformity with the standards of the HMO. Physicians who do not use more special services than the HMO deems to be normal may receive a bonus at the end of the year. Those physicians who "over-use" may forfeit the bonus or even lose a part of their salary. The HMO therefore supplies the physicians with incentives to reduce utilization.

THE RECIPE FOR CONFLICT OF INTEREST

HMOs, clearly then, seek to constrain costs. This is how they attract business away from traditional fee-for-service insurance plans. Furthermore, as shall now be discussed, these efforts to constrain costs do provide the conditions for a conflict of interests, both between the HMO and the patient and, more importantly for this essay, the physician and the patient. This section shall consider the potential for conflict of interest, whereas the next section shall consider whether this particular kind of conflict of interests represents an *ethical* conflict of interests.

The conflict of interest arises when the following two conditions are met:

1) There will inevitably (practically, though not logically inevitably) arise cases where the use of certain expensive, non-basic health care services would be of some benefit (however small) to the patient, but
2) There is a self-interested *incentive* (contrary to the interests of the patient) for the HMO and the physician to withhold the health care services in question.

These two conditions would seem to be easily, and indeed *frequently,* present in the typical HMO-physician-patient relationship.

Consider an infant suffering from an adenovirus infection. In rare cases this kind of virus can be quite aggressive and develop into viral pneumonia. The physician examines the child, listening to her lungs through the stethoscope. The physician is *relatively* sure that the infection has not spread to the lungs; the breathing sounds are reasonably clear. But that remote possibility lingers in the background. If costs were of no concern, the physician would almost certainly order a chest x-ray; but under the cost-conscious practice of the managed care environment, such a diagnostic procedure (though not inordinately expensive) would probably be seen as unnecessary unless there was greater risk of infection in the lungs.

As another example, a patient with acute headaches might *possibly* benefit from a full neurological workup, including a CT-scan, even though the most probable cause is simple stress. Given that stress is the most likely cause (in the particular case we have in mind) the HMO may provide an incentive to the physician to forego the full neurological workup on the grounds that as a general policy such interventions are not cost-effective. Such expensive intervention will not be forbidden absolutely, but physicians will be encouraged through incentives to reserve it for cases where the symptoms and history more clearly indicate a likely organic cause.

As a final example, the mother of a newborn infant, despite a lack of complications, may well benefit *to some extent,* in her physician's judgement,

from being allowed to stay in the hospital for several days before going home. Yet, the HMO may feel that such a stay is not cost-effective. (Remember, we are buying the no-frills Ford here, not the Mercedes.) The HMO may therefore make it awkward, bothersome, and difficult for the physician to permit the mother to stay in the hospital except that she pay for the extended stay out of her own personal financial resources.

These examples, which can be easily multiplied, illustrate how commonly conflicts of interest can arise between the HMO and physician, on the one hand, and the patient, on the other hand.

Why These Are Not Necessarily Ethical Conflicts

In essence, I shall argue here that this kind of conflict is not necessarily an *ethical* conflict for the reason that the consumer has *willingly chosen* to participate in this kind of health plan. However, before making that argument, let us review why some ethicists think that such a conflict is an ethical conflict and that it is unethical for physicians to take on this role of "gate-keeper."

The difficulty is seated in the traditional notion of the physician as having a strict moral obligation to have the patient's interest in mind when caring for the patient. The patient comes to the physician as a person in need—someone who is ill and vulnerable—and thus the patient *entrusts* the physician with his or her care. Any choice or action that the physician makes (a) on grounds other than patient welfare and (b) that is contrary to the welfare of the patient constitutes a violation of that moral trust that the patient has placed in the physician. Thus, for the physician to be an agent of the HMO or an agent for his or her own personal income in addition to being an agent for the patient is an inherently morally undesirable conflict of interests.

If we reflect upon how the patient enters into the care of the HMO physician, we may see how this is a misapplied criticism of HMOs, cost containment, and the gate-keeper role.

First, let us recall that the consumer/patient has voluntarily chosen to enter into agreement with a particular HMO, its coverage plan and the physicians within its practice network. That is, the consumer, working within certain economic constraints, has weighed the costs and potential benefits of various health insurance plans against the background of the costs and benefits of other goods and services, and has decided to purchase or contract with that particular HMO. This is quite analogous to the consumer comparing different makes and models of automobiles and settling for the basic model of a Ford automobile instead of the elegantly appointed Mercedes. The Mercedes, including its leather upholstery, anti-locking brakes and protective emergency air bags, costs more money than that particular consumer is willing to spend (relative to other desires).

Now the consumer, *knowing* that the very basic model Ford does not come with anti-locking brakes and air bags, is in no position to complain (after an accident) that Ford Motor Company withheld these items unethically. Since the consumer chose knowingly, he or she can not accuse Ford Motor Company of acting unethically, even if personal injury results as a consequence of the accident. (Please note that anti-locking brakes and protective air bags are not yet considered "basic" safety devices that federal transportation regulators require on all newly made automobiles.)

Analogously, the consumer chooses among health insurance plans knowing what their restrictions and limitations are. We purchase health insurance not knowing for sure just what our health care needs (or desires) will be in the future. We may make some educated *predictions*, based upon such factors as family history and current status, as to what we will need or desire; but such predictions necessarily lack certainty. They deal in the realm of probability. The consumer recognizes that in the case of certain *possible* eventualities, the health care plan that has been chosen will not be adequate to meet his or her desires/needs. But because those circumstances are relatively unlikely, the consumer is willing to discount the costs of their actually occurring. Being somewhat risk-averse, most consumers choose to purchase *some* sort of health care insurance; but because most consumers do not regard the worst case scenarios as definite eventualities, they are willing to settle for purchasing less insurance coverage than they might *possibly* need. So buying insurance is a kind of gambling—we are willing to pay enough to avoid the most likely bad outcomes, but we are not so risk-averse that we are willing to pay what it

would cost to cover for *every possible* bad outcome. We choose a compromise.

When the HMO physician refrains from a *slightly* possibly beneficial, but quite expensive, diagnostic procedure, he or she is engaging in behavior that in some sense conflicts with the interest of the patient. When he or she refrains from arranging a liver transplant because it will not be paid for by the health plan, he or she is, in a sense, acting contrary to the patient welfare.

However, when the physician practices such cost conscious medicine, he or she is practicing along lines of care to which the patient willing agreed prior to his or her illness. Just as in gambling with cards (or anti-lock versus no anti-lock brakes) there are winners and losers, so with health insurance there are winners and losers. The winners are those who purchase the insurance and subsequently develop needs that exceed the amount of money that they have contributed but that the insurance plan is designed to reimburse. The losers are those who purchase the insurance and never have great need of it (they put in much more than they take out) and those who develop rare and/or expensive conditions that the insurance plan does not cover. If the consumers buy into the HMO insurance plan, knowing its costs and conditions, it does not seem right to allow them to cry "foul" when they (through pure misfortune) become the losers. Thus, when the physician acts as a gate-keeper, he or she is in an important sense acting in accord with the *autonomy* exercised by the patient when that health plan was selected.

Since the gatekeeper physician is therefore acting in accord with an autonomous choice of the patient, he or she is acting in such a way as to fulfill that patient's *autonomy*. Hence, the physician is not acting contrary to the interests of the patient; rather the physician is acting upon the interests of the patient *as defined by the patient in the informed choice of a health plan*.

The Ethic of Managed Care and the Ethic of Hippocrates

Despite the efforts of some to see a solution to the dilemma in appeal to *both* the ethic of Hippocrates and some ethic of "informed consent," the ethic of Hippocrates and the ethic of managed care clearly conflict; but they conflict in an interesting way. In the Hippocratic tradition, the physician's ethical obligation is to the good of the patient, *as understood by the physician*. This is a natural stage for paternalism; and indeed paternalism had been the accepted practice for millennia, from the Hippocratic command to keep secret most important information from the patient (lest that self-knowledge cause self-harm) to the days of recent memory in American medical practice. (And I have chosen to overlook the continuing paternalism of medical practice in many other modern countries.) The ethic of managed care, as I have explained, can be understood, on the other hand, as founded upon respect for patient autonomy, particularly patient autonomy with regard to how much of one's resources to devote to health care insurance. Thus, the ethic of managed care is but a part of the age of respect for patient autonomy.

Rather than allow the matter to end simply here, let me point to two unsettling aspects of this argument, and the implications of those problems for our understanding of physicians as members of a profession. First, if the ethic of managed care is but a part of the respect for patient autonomy that has swept through health care ethics in America in the past couple of decades, then why is there such discordance between this ethic and what we outlined at the beginning of this paper as the popular conception of the ethic of Hippocrates? The answer, I fear, is that while the public has been willing to accept, even demand, the respect for their autonomy that health care ethicists have argued for, they and the health care professionals have taken a rather narrow view of what this respect for autonomy means. It has been taken to mean freedom of choice among possible options. But respect for autonomy, especially if we regard its Kantian origins, must also include respect for the financial choices that consumers make to limit the funds that they are willing to set aside for health insurance. Accepting freedom of choice also entails accepting responsibility.

Second, Kantian respect for autonomy is grounded upon the belief that the knowledge, the information required for making a rational choice, is readily available to mature adults. Yet when we contemplate the complexity of contemporary medicine as a practice, it is questionable that the average adult could be said to readily understand

the health care risks that he or she is running, in medical and financial terms, when he or she makes decisions concerning provisions for health insurance. At best, what must be assumed is that the individual makes a quite general weighing of the value of health care relative to other economic goods.

What both of these points illustrate is how the moral demand for respect for autonomy has cast more and more of the responsibility for choice, *including limits to choice,* upon the health care consumer. This leaves open to question, however, to what extent the physician remains a *professional,* in the traditional sense of the term that implied special moral obligations to the patient, obligations far beyond those of the ordinary businessman.

I do not wish to suggest that we summarily declare physicians to no longer be professionals, but I believe that, given our decision to respect patient autonomy, including in matters of finances, we as a society must rethink what it means, from a moral point of view, for a physician to be a *professional.*

Discussion Questions

1. Describe, in your own words, what you take to be the most serious conflict of interest that is generated by the practices of health maintenance organizations (HMOs).
2. While conflicts of interest often signal the existence of an ethical conflict, Waymack suggests this is not necessarily the case here. What is his reasoning? To what extent do you agree?
3. What moral theory (or theories) support Waymack's point about consumers making a choice among different health care packages? What moral theory (or theories) could support criticisms of his position?
4. Does Waymack's reasoning allow for an ethically appropriate balance between profits on one hand and the interests of patients on the other? How might Freeman's stakeholder view (Chapter 5) be applied to this question?

Physicians and Managed Care: Employees or Professionals?

KATE T. CHRISTENSEN

THE DELIVERY OF HEALTH CARE in this country is undergoing a profound transformation, as evidenced by the almost daily news reports of megamergers among hospital systems. One dominant emerging theme is the corporatization of health care delivery, with nonprofit health care systems converting to for-profit status, and the public health system either collapsing or converting to private enterprise. Most of these health care systems are or will become organized as for-profit managed care entities. It had been predicted that by the year 2000, managed care organizations (MCOs) will provide the majority of health care services, and that within twenty years (Rodwin 1993), the majority of physicians will be salaried by an MCO (Friedman 1993).

Given the scope and pace of these changes, the current debate over the pros and cons of managed

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care versus fee-for-service is rapidly becoming irrelevant. Instead, we need to analyze the features of managed care that best promote patient welfare and those that do not. I believe that the MCO that results in the highest quality of patient care is the one that minimizes incentives to withhold care and in which physicians control clinical practice (Christensen 1995).

The for-profit staff model MCOs typically put physicians in the role of employees with the resultant loss of control over practices and incomes. These MCOs often use negative financial incentives to discourage overuse of the health plan's resources. By comparison, the nonprofit group practice HMO structure holds the greatest potential for promoting both physician autonomy and benign financial incentives. Belonging to a group practice instead of being employed by an HMO gives physicians the opportunity for greater control over such crucial practice functions as utilization review and quality control. And because the nonprofit plans are not obligated to maximize net profits in order to satisfy shareholders, there is less need to employ perverse incentives to squeeze extra profits out of the physicians' practices. This arrangement offers the best opportunity to combine managed care with quality care.

Professionals or Employees?

Traditionally, physicians have considered themselves professionals, highly trained practitioners of the art and science of medicine. Our society has endorsed this role by rewarding physicians with generous incomes, respect bordering on reverence, and a great deal of professional autonomy. Most physicians in fee-for-service have been self-employed, and, until recently, have had control over their practice styles and schedules.

However, with health care services becoming big business, physician income and autonomy are rapidly eroding. Within the medical profession, we now see a spectrum of physician autonomy, from the complete control over one's practice in pure fee-for-service, to the employee status of physicians in some of the staff model MCOs. The growing dominance of managed care in many urban areas has created a situation in which thousands of physicians are leaving independent practices and becoming either employees of MCOs or indentured to them through contractual arrangements. In doing so, they may gain the benefits of working in an integrated group setting but at the same time face a diminution of their professional autonomy.

For those who work in for-profit staff model MCOs, this loss of autonomy can be dramatic. As employees, they are subject to sudden discharge, unpredictable drops in income, and changes in their schedules or professional duties. Other physicians may work with MCOs through their independent practice associations (IPAs). These physicians keep their private practices and self-employed status, thus maintaining some control over their practice and working conditions, but their remuneration is still subject to market pressures and changing conditions of the MCOs that pay them. At any time they may find themselves "decapitated and disempaneled," often without advance notice or justification.

For all these physicians, clinical skills have become just one more commodity the MCO offers to the public as an inducement to enroll. But as the most expensive commodity, many MCOs will reduce the amount paid to physician-employees as much as the job market will allow. Some will argue that physicians' incomes have been over-inflated in recent years, and that this downward trend is a welcome correction. Nevertheless, given the current oversupply of physicians in urban areas (in particular subspecialists), combined with market pressures, the decline in physician incomes has not yet reached bottom.

Why is physician income important to maintaining quality patient care? The amount physicians are paid is not so important (except to physicians), but the loss of control over income, coupled with the nature of financial incentives employed by the MCO, can create a harmful conflict of interest within the physician-patient relationship and threaten patient care.

Physician Incentives and Patient Care

As physicians lose control over incomes, new measures are being used to reshape how physicians are paid. MCOs are using their new control over income as a way to influence their physicians to comply with the standards or guidelines of the organization. Various incentives are employed to

minimize utilization of health plan resources and optimize patient outcomes. When these incentives emphasize the former goal over the latter, conflicts of interest and degradation of patient care may result. The type of incentives used and how they are applied also can have an impact on patient care and the ethical conflicts experienced by conscientious physicians (Emanuel 1995).

Some incentives, appropriately applied, can serve as a needed nudge to encourage a physician to follow state-of-the-art practices, apply preventive services effectively, and avoid wasteful overuse of tests and procedures. Other incentives, however, may create a conflict of interest, pitting the physician's economic self-interest against his or her commitment to good patient care. For example, many MCOs pay bonuses to physicians, or release a withheld portion of income, for meeting specific cost and utilization targets. If the physician is paid a basic salary, which is in the range for his or her specialty, then the bonus money is unlikely to influence treatment decisions. But if the bonus or withheld income makes up a significant portion of the physician's income, the temptation to compromise patient care to meet specific goals is heightened (Council on Ethical and Judicial Affairs 1995). In the for-profit MCOs, the percentage of income withheld is in the highest end of the spectrum, often more than thirty percent.

The criteria used for rewarding bonuses are also important. Health care organizations use a variety of criteria to decide who gets a larger bonus and who does not. Those criteria range from the benign—evaluating physicians on the basis of the quality of care, patient satisfaction, and efficient use of resources—to the malignant—grading physicians according to certain cost-containment measurements and punishing or rewarding accordingly. Given that physicians have their own internal incentive systems based on a commitment to do their best for their patients, these reward systems still can cause moral stress when they pit the good of the patient against the physician's own self-interest. Rewarding good patient management creates much less conflict for physicians than rewarding cost-containment. For example, if the largest bonuses are rewarded to those who have ordered the fewest tests, a physician will have a negative incentive to provide important preventive services such as mammograms. If physicians are rewarded for preventing hospitalizations, they will have added motivation to keep their patients well.

Physician Practice Autonomy Under Managed Care: Utilization Review and Practice Guidelines

Along with loss of control over incomes, many physicians also have experienced loss of control over their clinical practices. External utilization review and requirements for pre-approval for tests, treatments, and admissions to the hospital are creating new constraints on the way physicians practice medicine. In general, staff model for-profit MCOs tend to employ these intrusive management methods more than the non-profit MCOs. Utilization review can be a barrier to good patient care when performed by someone who has no clinical experience and makes treatment decisions based on written algorithms and protocols. However, when managed and implemented by physicians, utilization review can both promote better patient care and save money. It can minimize unnecessary treatments or hospital stays, and encourage preventive care. It is a different experience for a physician to get a call from a colleague, asking if the patient with pneumonia really needs to remain in the hospital, than to get a call from a reviewer in a distant city who informs the physician that reimbursement will be discontinued if the patient remains in the hospital. In the first scenario, the two physicians can discuss whether there are exceptional circumstances that mandate continued hospitalization or if, as is often the case, discharge is being postponed until a convenient rounding time for the physician. Utilization review should not put up barriers to good patient care, and in the hands of physicians, it is less likely to do so.

Practice guidelines are another feature of practice management that can have an important impact on patient care (Eddy 1993). When applied inappropriately, practice guidelines are imposed on physicians and used as standards to measure, reward, and punish physician behavior. But when physicians are involved with development and implementation of practice guidelines, this process can become a useful extension of peer review and help to maintain a high quality of care. For example, Kaiser Permanente physicians were

involved in an important clinical research
which showed that routine screening of th
for colon lesions is only useful after the ag
and then only every ten years in low-risk
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Conclusion

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Discussion Questions

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involved in an important clinical research project, which showed that routine screening of the bowel for colon lesions is only useful after the age of fifty and then only every ten years in low-risk persons (Selby et al. 1992). Adapting those guidelines into the clinical practice of Kaiser Permanente primary care physicians has not been difficult because they trust the data and those who developed the guidelines. Furthermore, they know that they will not be penalized for ordering a colon test for a patient more frequently, or at a younger age, if they believe it is necessary. Applied with physician involvement, it is less likely that guidelines will be mistaken for standards (which require more stringent outcomes studies and stricter enforcement) and less likely that practice guidelines will be used to reward and punish inappropriately (Crosson 1995).

Conclusion

We are moving rapidly into a future in which physician autonomy and income arrangements will be changed forever. Physicians will be more accountable to the health plans which pay them, to the employer groups and health plan enrollees who provide the funds, and to the other physicians in their MCO. These changes can ultimately improve the practice of medicine. But this loss of physician autonomy must be tempered by the involvement of physicians in the "manage" part of managed care. If physicians are restricted to providing only the "care," as employees who vend their services without playing a role in practice management, they will suffer increasing moral stress, and quality of care will suffer as well.

Under the umbrella term "managed care" there are important variations in financial incentives and physician involvement in clinical practice management. A system that rewards good outcomes and patient satisfaction, which does not withhold a crucial portion of physician income, and which involves physicians in the development and implementation of practice guidelines and utilization review, will in the long run provide the best patient care. Because the nonprofit, group model MCOs more often embrace these principles and practices, they hold out the best hope for balancing cost-control with the highest standards of patient care.

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Discussiozn Questions

1. According to Christensen, what is the basic difference between a for-profit and a not-for-profit managed care organization? What is the difference in the way each operates?
2. Describe the problem with which Christensen is primarily concerned. Why does she believe that only one version of the managed care organization will solve this problem? To what extent do you agree with her view?

3. How might one use contractarian ethics to support Christensen's claims? What other moral theory (or theories) could be used to support her claims? What moral theory (or theories) could be used to criticize her claims?

Cases

Case 7-1

Thomas Holiday moved to Chicago three months ago in order to take a better job. He has asthma and needs to locate a doctor to fill his prescriptions. Thomas knows how important it is to find a doctor who understands his condition. He has visited several different physicians. Some would basically make decisions for him without discussing the matter with him in any real detail. Some asked him lots of questions, trying to determine his values, and then insisted that the right medical decision for his asthma would be the one most closely aligned with those goals. Thomas has come to understand what sort of physician he does not want, but is not exactly sure how to describe the sort of physician he does want; he just knows he needs one who will talk with him about his health care requirements.

1. In light of the article by Ezekiel and Linda Emanuel, what kind of physician would you say Thomas Holiday needs? Again using that article, how would you describe the kind of physician he does not need?
2. Would it make a difference if Thomas's asthma condition were more serious, or would the same sort of physician-patient relationship be in order? Can you think of any medical ailment Thomas might have that would make a different physician-patient relationship appropriate?
3. Can you support your answers to the previous questions using virtue ethics? Using any other moral theory (or theories)?

Case 7-2

Dr. Timothy Watson always wanted to be a physician and as a young intern worked hard to establish himself. He has now become quite successful, earning the respect and trust of many people in the community who rely on his expertise and professional judgment. Dr. Watson can, however, be heavy-handed at times; his primary concern is the health of his patients, and other considerations—including the wishes of the patients themselves—often take a backseat to his goal. One might say he often acts paternalistically, sizing up a patient's medical situation and acting accordingly without fully explaining that situation to the patient. In his mind, the patient does not need to know all the details, which most patients would not understand anyway, since his role as a doctor is to provide nothing less than expert medical treatment. Indeed, he thinks the whole idea of informed consent is overblown, and more strongly is "just bad medicine," since it allows patients the opportunity to choose inferior alternatives or even to refuse medical treatment altogether.

1. According to Meisel and Kuczewski, Dr. Watson has fallen prey to certain myths about informed consent. Describe those myths, and explain how you would try to convince him that informed consent is not, in actuality, "bad medicine."
2. Can you think of certain kinds of cases that would justify Dr. Watson's paternalistic approach?

3. Imagine that Dr. Watson thinks that a three-year-old boy, who of course cannot give informed consent to anything, should be treated in one way, while the parents of the boy think he should be treated in a different way. Whose decision should it be? If Dr. Watson were to argue that his extensive medical training makes him more qualified to determine the best course of action, how persuasive would his argument be? Would it make a difference if the boy's life could be easily saved with a simple blood transfusion, but because of religious beliefs the parents are opposed to blood transfusions and choose to let their son die?

Case 7-3

Mary knew why her best friend Sara was calling. She knew Sara's overall condition had continued to deteriorate as a result of the inoperable cancer. Now, Sara said, she was ready to die—on her own terms, in her own way, and not on the terms set by an awful disease which, as she put it, "is robbing me of my dignity." Mary, a nurse, had agreed two months ago to help her friend in ending her life. Mary was still worried; because she was not as knowledgeable as a doctor, she feared making a mistake with the "dosage" and leaving her friend in a vegetative state. Sara, however, had refused to consult with a doctor, saying that dying was too personal to involve anyone who was not a close friend.

1. Is Mary's arrangement with Sara ethically permissible? Is Mary's role as a nurse ethically relevant, or does her role as a friend take precedence? How would it affect the ethics of the case if Sara were one of the patients under Mary's care in the local hospital?
2. If state law prohibited assisted suicide, would it matter ethically?
3. How are Tania Salem's ideas relevant to this sort of case? How are Lucie Ferrell's ideas about "nursing as caring" relevant?

Case 7-4

John's heart stopped and his brain was without oxygen for several minutes. The paramedics arrived quickly and eventually were able to restart his heart, but John has not regained consciousness and probably never will. The damage caused by the heart attack, to both his brain (from lack of oxygen) and to the cardiac tissue itself, is extensive. Emily is now coming to terms with the reality of the situation, which entails some difficult choices. Agreeing to allow the removal of her husband from life support, which would bring about his death quickly, is an option, but Emily is hoping for a miracle, hoping that one day John will awaken and be all right. She has found herself asking what John would want. He always was an optimistic person, and perhaps he would be optimistic even in this case. The hospital bill, meanwhile, is becoming astronomical, and the physician firmly believes that John's chances of recovery are vanishingly small.

1. What should be the most important factor in the decision of whether to remove John from life support? (Medical costs? John's previously stated wishes?)
2. Imagine that John indicated to Emily years ago that if something like this were to ever happen, he would want to be kept alive as long as possible, no matter what. How relevant is this? What would Thomas May say?
3. Turning off John's respirator would be taking an action that would bring about his death. Is there any ethical difference, therefore, between this case and the previous

one in which Mary would be taking an action that would bring about her friend Sara's death?

Case 7-5

No matter what Terri Martin tries to do, she cannot keep up with the demands of her patients. Terri is a charge nurse, working for a private hospital that is operating on a shoestring budget. Times are changing: medicare benefits for patients are being cut, insurance benefits for paying customers are covering fewer medical services, the building itself needs repair, and the ward badly needs new medical equipment. Terri has seen better people than herself let go for economic reasons. She likes her job but the pressure is beginning to take its toll. The ten pediatric patients she takes care of are demanding, and she senses that it is only a matter of time before facing a situation where two patients need immediate attention and she will only be able to attend to one. Pointing this out to the administration does not seem to help. The physicians, meanwhile, come through each day and leave their orders without staying very long; they have got their own problems with insurance companies and the like. Terri wonders if things will ever get better. Such unfair pressure cuts at her love for her work.

1. Tuckett employs the analogy of the Good Samaritan to understand the kind of person a nurse should become. In your opinion, how could Terri benefit from this analogy?
2. Suppose for the moment that you are in a position to create a code of ethics for nursing. How would you address this problem? What kind of rules would you create and what moral theories would you use to justify those rules?
3. In their article, the Emanuels discuss four models of the physician-patient relationship. Using that article, attempt to create four models of the nurse-patient relationship.
4. In light of Ferrell's article, how might Terri's situation be a "dilemma of caring"? What are the risks of her continuing to accept additional responsibilities? What are the risks of her and the other nurses going on strike or doing something significant to make it clear to the administration how serious the problems are?
5. What other concerns raised by Ferrell might be relevant to this case?

Case 7-6

Rains Health Center has been serving the local community for twenty years. It has high standards and a good reputation for quality health care in the community. Unfortunately, increasing cuts in medicaid and medicare, the escalating cost of insurance rates, and the growing denial of coverage of medical therapies make quality health care difficult to come by. The partners of Rains believe that in order to maintain their commitment to the health care needs of the community, the center must become associated with a health management organization (HMO), an alignment that would help hold down costs and keep health care affordable. Additionally, because it would be a nonprofit group practice, the partners think that such a move would maximize physician autonomy in terms of case management and financial incentives. However, patients of the center have expressed concerns that the quality of care may decline, and some administrators believe that alignment with a for-profit managed care organization (MCO) would be a better way to address the current financial difficulties.

1. If Rains Health Center were to go the
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1. If Rains Health Center were to go the HMO route, would the patients be justified in their concern over lower quality of care? Would such a decline be ethically problematic? If so, why? What would Waymack say?
2. If Rains Health Center were to go the MCO route, some physicians would be concerned about becoming "employees" of the MCO and the associated loss of autonomy. Would they be justified in their concern? Would such a loss of autonomy be ethically problematic? If so, why? What would Christensen say?
3. Given the financial worries of the center, the partners claim that modest compromises must be made in terms of physician autonomy or the level of patient care, or maybe a little of both. How might the competing considerations be "weighed" in this difficult case? How might one analyze this case by using Freeman's stakeholder approach (Chapter 5)?