

Right or Wrong: Policy, Legal and Ethical Issues, and Decision-Making

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Nurses make decisions every day that must take into account health policy, laws, and ethical standards. Therefore, in order to make appropriate decisions, nurses require an understanding of how policy, laws, ethics, and nursing interface. This chapter provides a compelling case study that occurred in Nebraska and underscores the importance of nurses being constantly aware of proposed health policy, changing laws, petition drives, and ballot initiatives and their ethical implications. The Nebraska case study shows how proposed policy, legal issues, and ethical factors affect clinical nursing practice and how nurses must consider all aspects when making decisions in their practice.

Nebraska Case Study

In the summer and fall of 2006, a group of individuals from states outside of Nebraska wrote and financially funded a petition drive to obtain enough signatures to promote an amendment to the Nebraska

state constitution (Stoddard, 2006a). The proposed amendment was titled “Nebraskans for a Humane Care Amendment.” For the proponents, it would ensure a legal mandate that all individuals in Nebraska with a terminal condition would not have medical interventions, food, or water withheld or withdrawn. However, the amendment did include a statement that it would respect individuals’ advance directives if they fully expressed a desire to withhold food and water in terminal conditions. The opponents of this petition had the following concerns:

- The initiative was from out of state.
- Only one or two Nebraskans had any involvement, which was a minimal legalistic engagement.
- If passed, the policy would create ethical dilemmas for patients, family members, and healthcare providers because the proposed amendment mandate did not reflect medical or ethical best practices for patients in terminal conditions.
- The amendment would take decision-making away from parents about their children’s conditions.

In early September 2006, the Nebraska secretary of state ruled that the petition organizers had not obtained enough valid signatures to have the petition put on the November 2006 election ballot (Stoddard, 2006b). He disqualified many of the signatures that had been obtained for a variety of reasons; as a result, the amendment was not on the ballot for Nebraskans to decide in fall 2006. The policy activists, including many nurses, involved in resisting the 2006 policy were attentive in 2007 and 2008 in case another petition was initiated. In the 8 years since that proposed policy, there has not been another such policy initiation. Thus, although policy did not become a mandate for patients, family members, nurses, healthcare providers, institutions, and other policy and healthcare actors in the healthcare system, it is an exemplar case because of the intersection of policy, legal issues, and ethical aspects within the context of nursing practice.

Potential Implications for Practice

Had this amendment to the Nebraska state constitution been placed on the November 2006 ballot and voted on by Nebraskans, successfully passed, and become law, Nebraskan nurses would have had to follow the law or face penalties. Their nursing practice with patients in terminal conditions and their family members would have been mandated by this state constitutional amendment. A nurse who practices in a hospice setting, whether in a hospital, nursing home, or patient’s home, would be mandated to continue administration of hydration and nutrition by artificial means even if not based on best practices.

In such a situation the nurse would be compelled to implement interventions because of the constitutional amendment (Nebraskans for Humane Care Committee, 2006). Thus, one can see the tension in decision-making between making decisions based on best practices, as in evidence-based practice, or decision-making based on proposed policy and law, but not based on clinical research.

Ethical concerns further complicate the nurse's decision-making process in this Nebraska case study. Nurses must balance their decisions based on what evidence-based practice dictates, what the law mandates, and what the ethical dilemma calls for. For example, perhaps the patient did not want the administration of hydration or nutrition but had not created an advance directive. Without that legal document, the patient, family, nurse, other healthcare providers, and others in the healthcare institution could not advocate for what the patient wants. Nurses have a responsibility to follow the American Nurses Association (ANA) Code of Ethics (American Nurses Association, 2012). In such a situation, nurses may well fail in their role and responsibility of being an advocate for the patient and to advocate for what the patient wants because they fear the penalty of law. Thus, nurses could be violating their own professional ethical code. They can, however, seek support when making their decisions (thereby perhaps decreasing their ethical dilemma) by considering the expectations of nurses in both the American Association of Colleges of Nursing (AACN) master's essentials and baccalaureate essentials documents. For example, in this Nebraska case study, nurse policy activists implemented all five of the knowledge outcomes found in the master's essentials; that is, (1) they analyzed the proposed policy for possible outcomes; (2) they participated in state policy activism; (3) they examined the policy and the legal effects of the proposed constitutional amendment for patients, family members, and nursing practice; (4) they based their activism on both research and the ANA Code of Ethics; and (5) they were strong advocates for patients, family members, the nursing profession, other healthcare providers, and the healthcare system (American Association of Colleges of Nursing, 2011).

What Nurses Need to Know and Do

The Nebraska case study signifies what nurses need to know and what nurses need to do to be in control of their profession and to be advocates for their patients. Nurses need to be able to read and understand legal language so they can analyze how that language will affect their practice and their patients. In this case, nurses needed to know the language of the Nebraska Humane Care Amendment, Section 30, which said (Nebraskans for Humane Care Committee, 2006):

The fundamental human right to food and water should not be denied to any person, regardless of race, religion, ethnicity, nativity, disability, age, state of health, gender, or other characteristics: No entity with a legal duty of care for a person within its custody (including a hospital, orphanage, foster home, nursing home, sanitarium, skilled nursing facility, prison, jail, detainment center, corporation, business, institution or individual) may refuse, deny, or fail to provide food and water sustenance and nourishment, however delivered, to any such person if death or grave physical harm could reasonably result from such withholding and the person at risk can metabolize. Any such person so threatened with dehydration or starvation, any relative of such person, such person's legal guardian or surrogate, any public official with appropriate jurisdiction, or any protection and advocacy or ombudsman agency shall have legal standing to bring action for injunctive relief, damages and reasonable attorney's fees to uphold this standard of humane care. This section does not prohibit honoring the will of any person who, by means of a valid advance directive record, has fully expressly, and personally either authorized the withholding of food or water from himself or herself under specific conditions, or delegated that decision, under specific conditions, to one or more relatives or to another person unrelated to the entity with a legal duty of care.

It is important for nurses not only to be attentive to legal language and to understand that language, but also to critically think about how it affects their decisions. For example, a critique of the language in the proposed amendment reduced the patient to a biological determinant or to a biochemical definition of a human being, especially with the word *metabolize* (J. Welie, personal communication, October 23, 2006). Aside from the language being reductionistic of a human being, the choice of the word *metabolize* is incorrect because there is some metabolism after death. It is incongruent with the ethical practice of nurses to practice such reductionistic nursing care. Analysis of other language reflects that minors (and their families) would not have any decision-making rights. When nurses analyze potential laws that interfere with their ability to deliver quality ethical care to patients, they must intervene. Many nurses in Nebraska did exactly that by being part of the coalition group that formed in opposition to this proposed constitutional amendment.

Although most nurses think of laws when the word *legal* is evoked, the Nebraska case study educates nurses to another important dimension, which is a petition drive to add an amendment to a state constitution, the highest law of one's state. Further, no state law may be in contradiction to constitutional law. This petition drive was

promoted by individuals and groups outside of Nebraska. A group, America at Its Best, with a postal address in Kalispell, Montana, was responsible for all of the \$835,000 funding for the petition drive for the Nebraska Humane Care Amendment (Stoddard, 2006a). The same group provided almost all of the \$861,998 for a second petition drive titled, Stop Over Spending Nebraska, whose purpose was to limit state spending. Only \$1,998 was donated by people or entities others than the America at Its Best group (Stoddard, 2006a). This group listed the following national organizations as its supporters: Americans for Limited Government, Club for Growth, Funds for Democracy, and the National Taxpayers Union. In Nebraska, 113,721 valid signatures, or about 10 percent of registered voters, are needed on a petition ballot for it to be voted on at an election (Stoddard, 2006a, 2006b). The Nebraskans for Humane Care Committee turned in 137,200 signatures.

As noted earlier, nurses need to be able to analyze the use of language by others. Group titles and petition titles can be misleading and/or mean the exact opposite of what a citizen might think the language means. Many Nebraskans signed the petition thinking that the proposed amendment was a “good” thing because the title sounded positive (i.e., who could be against humane care?). Eventually, the Nebraska secretary of state found the group did not have enough valid signatures to put the petition on the ballot; about 20 percent of signatures had been declared invalid by county election officials (Stoddard, 2006b). Although this was because of a variety of reasons, one variable will be noted here—individuals who signed were given incorrect and/or fraudulent information when they were asked to sign the petition by the petition seekers. This has ramifications for nurses in their professional and civic lives. When nurses are aware of such misleading or fraudulent behavior on the part of amendment signature seekers, they must be activists. Such policy activity could take several forms: educating their colleagues, family, friends, and neighbors; writing letters to the editors of local newspapers; joining coalition groups engaged in the policy issue; and so forth.

Legal Aspects

Nurse Practice Act

One of the most important laws affecting nurses is the nurse practice act of their state because it provides the legal authority to practice their profession. The Nebraska case study emphasizes the importance of nurses being attentive to legal and ethical dimensions of their practice. This author believes every nurse has been educated and socialized

to respect their nursing license. Nurses know about the necessity of passing the National Council Licensing Exam for Registered Nurses (NCLEX-RN), of obtaining and maintaining their nursing license, of knowing the nurse practice act in the state in which they are practicing nursing, of knowing and working within their nursing scope of practice, and of keeping informed about changes in nurse licensure issues. Further, because we live in a litigious society, nurses know the frequency of lawsuits and want to avoid possible loss of their license, termination of their employment, and involvement in a lawsuit as the defendant.

Thus, a core legal aspect for every nurse to know is the importance of her or his state nursing practice act. Because “nursing practice is regulated by each state through a board of nursing established by the state’s government” (Wright & DeWitty, 2005, p. 3), nurses must understand what these laws are and how they dictate their practice. A nurse’s professional life and economic livelihood are intimately related to the nurse practice act he or she needs to follow. Violating parts of that act can result in employment and licensure penalties. In every state a Board of Nursing has the responsibility and authority to: (1) issue nursing licenses, (2) regulate the practice of nursing, (3) enforce and interpret the specific state’s nurse practice act, (4) promulgate administrative law (rules and regulations) that further clarifies the actual law, and (5) discipline nurses as necessary for the goal of ensuring the public’s safety in the area of nursing care (Wright & DeWitty, 2005). In addition, a state Board of Nursing may give advisory opinions to nurses and other interested individuals with questions and concerns about the scope of nursing practice (Wright & DeWitty, 2005).

Advisory opinions do not have the force or effect of law but generally are issued by a state board in response to evolving issues affecting nursing practice, such as mandatory overtime, or questions related to the scope of practice, such as the peripheral insertion of central venous catheter lines. (p. 4)

For example, in Nebraska there are 40 advisory opinions listed on the Nebraska State Board of Nursing Web site (Nebraska Health and Human Services, n.d.). Many of these opinions relate to the proposed amendment discussed in this chapter, including the topics of “Abandonment” and “Accountability for Professional Conduct of Nurses.”

National Council of State Boards of Nursing

Web-based technology and use of the Multistate Nurse Licensure Compact for nurse licensure in many states have increased the helpfulness of the National Council of State Boards of Nursing (NCSBN) for

nurses and nurse managers. The NCSBN provides a variety of services to the Boards of Nursing of all 50 states, the District of Columbia, and the five U.S. territories. These services include (Wright & DeWitty, 2005):

- Leadership on common concerns
- Development of the national nursing licensure examination (i.e., the NCLEX exam)
- Research and policy analysis
- Promulgation of national uniformity in the regulation of nursing practice

The technology system established by the NCSBN enables all state Boards of Nursing to have access to data regarding nurses' licenses and discipline information. Employees of any state Board of Nursing can enter or edit data, obtain data on past licensure or license discipline of nurses, and the like. Nursing employers can access this data for a fee. The general lay public cannot access this data. Besides verifying nurses' applicant license information, a Board of Nursing employee may also use the data system to review disciplinary information of a nurse and to electronically communicate between and among staff at other Boards of Nursing. This system is especially important given the increased mobility of many individuals and nurses in U.S. society, because of the Multistate Nurse Licensure Compact and the use of short-term travel nurses to meet patient needs. Nurses will find the Web site to be a helpful resource. If short-term travel nurses are coming and working in Nebraska, for example, they can use the Web pages of both the NCSBN and Nebraska's State Board of Nursing to better inform themselves of the kinds of laws, policies, and advisory opinions they must know to practice within their scope of practice in Nebraska.

The NCSBN took a leadership role in the 1990s when it studied and promoted a multistate Nurse Licensure Compact model for nursing licensure. This model has now been passed by state law in 24 states. See the NCSBN Web site for a listing and map of the states that have this model (www.ncsbn.org). This model, based on the driver's license model, allows a nurse to obtain a nursing license in their state of residency (home state) and then practice in other states that also belong to the Nurse Licensure Compact. The nurse is subject to the nurse practice act of the state in which the nurse is practicing. When practicing in multiple states that belong to the compact, the nurse has one nursing license: that of their home state (i.e., where the nurse resides). States have to pass laws to join the compact. This is yet another example of how laws and policy affect the practice of nursing.

It is the state Board of Nursing that addresses any complaints about a nurse; such complaints may begin the discipline process of

that particular state board. Complaints about a nurse could come from a range of individuals: patients, family members, nursing or other work colleagues, employers, or individuals outside the work setting. “The most common complaints filed arise from known or suspected chemical impairment and abuse; drug diversion; criminal convictions; professional boundary violations; and practice deficiencies such as medication errors, documentation discrepancies or the failure to assess or intervene appropriately” (Wright & DeWitty, 2005, p. 6). Although particular practices may vary from one state Board of Nursing to another, there are three common steps for a nurse to anticipate after a discipline investigation has been initiated: the Board of Nursing will conduct an initial investigation, the nurse is informed, and then there will be further investigation, which results in a range of possible outcomes—from dismissal of the complaint to formal charges against the nurse. If a nurse is disciplined, the discipline action could be one of the following:

- An advisory letter
- A public reprimand
- Probation with monitoring by the Board of Nursing
- Suspension from nursing practice for a designated time period, which may include stipulations for reinstatement
- Revocation of one’s nursing license, either permanently or nonpermanently

Because the discipline investigation context is adversarial and because one purpose of a state Board of Nursing is to protect the public regarding nursing care, nurses are advised to seek legal counsel with an experienced attorney in such an investigative situation.

A state constitution supersedes other state laws including a nurse practice act. If the Nebraska case study amendment had been voted on and passed by Nebraskans, nurses (and others) would have had to follow that constitutional amendment in terms of how they would treat all patients in the state. If the nurse chose not to (because of advocacy for the patient based on evidence-based nursing practice or ethical analysis), the nurse would be subject to penalty of law—and, further, would be in conflict with some goals of the nurse practice act administered by the Nebraska State Board of Nursing (to deliver competent, safe care to patients). Further, the nurse would be in conflict with her or his ANA Code of Ethics as well as other ethical principles.

It is beyond the purview of this chapter to include all aspects of the law and nursing. Nursing practice is affected by a multitude of federal, state, county, and city laws; by lawsuits against nurses; by rules and regulations; and by the precedent of court cases. In the following section, the Nebraskan case study is examined in terms of how policy and legal issues integrate with the ethical decision-making process.

Ethical Decision-Making

The Nebraska case study is also significant because of its ethical concerns. Nurses experience moral anguish when they engage in ethical dilemmas that concern patient care. Although there are many challenges facing nurses in the work environment (e.g., high patient-to-nurse ratios, mandatory overtime, worksite violence, and several others), it is the ethical and moral dilemmas that cause the most pain for nurses. The Nebraska case study is only one example of the kind of frustration, tension, and dilemmas that nurses have. Nurses experience moral anguish with the high patient-to-nurse ratio and knowing that best patient care is not being given. They experience moral anguish when mandated to work overtime—attempting to balance not abandoning their patients with their concern about not giving quality care and their fear of risking a lawsuit because of fatigue and increased risk of medical errors.

In making ethical decisions, three resources that are valuable for nurses are: (1) the ANA Code of Ethics, (2) an understanding of ethical principles, and (3) the AACN master's and baccalaureate essentials documents. The ANA Code of Ethics was revised in 2001. Although discussion of the Code in this part of the chapter concerns ethical dimensions, it also could have been emphasized in the previous policy and legal section of the chapter. For example, if a nurse is involved in a lawsuit, one of the factors that will be analyzed is: Did the nurse follow the ANA Code of Ethics? This is considered a standard of practice. If the nurse did not follow the Code of Ethics, the nurse's practice is considered substandard. Defense attorneys prepare and coach nurse defendants in lawsuits to be prepared for this line of questioning by the plaintiff's attorney (i.e., is the defendant nurse knowledgeable about and following the ANA Code of Ethics in her or his practice?).

Historically, one way of understanding ethics in the health system is to study ethics in terms of ethical principle—in other words, nonmaleficence, beneficence, fidelity, autonomy versus paternalism, veracity, and justice (Purtilo, 2005). This is the language commonly and routinely used and found in nursing and health literature, heard when participating in institutional ethics committees, and heard when other nurses and healthcare providers analyze ethical dilemmas. In addition to these, a discussion follows on the Ethics of Caring theory, which has emerged as another way of solving ethical dilemmas. This latter model comes from the work of Gilligan (1982), other feminists, and nurses.

The principle of *nonmaleficence* is not harming another (Purtilo, 2005). Nurses constantly aim to practice this ethical principle and hold it foremost in their practice. They do not want to harm patients;

further, they are healers, are ethical, and, given one aspect of this chapter, they do not want a lawsuit against them. In re-examining the Nebraskan case study, if there had been such a constitutional amendment in Nebraska, nurses would have had to choose between following the law and implementing what they know about risks and complications of sustained artificial hydration for dying patients. For example, there is clinical evidence that provision of hydration and nutrition in end-of-life illnesses may cause suffering and may increase aspiration pneumonia and bloating (Post & Whitehouse, 1995). Thus, a law could force nurses to harm a patient. There are a multitude of other examples that occur on a daily basis, where nurses make decisions, practice preventive interventions, revalidate orders, and use critical thinking and nursing judgment to prevent harm to patients. It can be said that the nurse is the patient's last defense. Nurses' attention to not causing harm to patients has greatly increased in the past decade because of the wide professional and lay media coverage of the problem of medical errors in the healthcare system (Milstead & Furlong, 2006).

The next principle is *beneficence*, which is bringing about good for the patient (Purtilo, 2005). In the Nebraskan case study, the proponents and the opponents of the proposed amendment differed on their analysis of this principle. The proponents saw this amendment as being positive for the patient. The opponents evaluated other dimensions to the issue (i.e., that it may bring clinical harm to some patients or that it violated other ethical principles, such as patient autonomy, fidelity, and justice). When reflecting on one's nursing practice, the usual situation is that every day a nurse works, she or he is making many decisions that are beneficent for the patient. To integrate with legal content discussed earlier in this chapter, the nurse practices beneficent nursing care that meets standards of care and the Code of Ethics. However, it should be easy for the reader to think of many situations for which there can be honest differences of opinion, values, and evaluation of situations—one person can evaluate that an intervention is harmful and another party can analyze the intervention as beneficent. This is the ethical dilemma and is the dilemma for this case study. There is a difference of analysis and evaluation of the beneficence of mandated hydration and nutrition for patients in terminal conditions. Three authors wrote articles during the summer of 2006 analyzing the Catholic moral tradition about end-of-life issues that apply to this case study. One writer, Shannon (2006) "sees the preservation of life at all costs as at least highly troubling, if not as a radical move against the Catholic medical ethics tradition" (p. 29). Drane (2006) analyzes the history of Catholic moral tradition and argues against the provision of artificial nutrition and hydration for all patients. Father Kevin O'Rourke (2006), a noted Catholic theologian and ethicist, argues for balancing

costs with benefits when making decisions about artificial nutrition and hydration. He stresses the importance of decision-making by the patient, family members, and healthcare providers. His arguments for who should be the decision makers would be in opposition with the proposed amendment where the state government would be making the decision.

The third principle is *autonomy versus paternalism* (Purtilo, 2005). This means respecting the decision-making of the patient and/or the family members versus only considering the wishes of the healthcare providers in deciding treatment plans. There has been a paradigm shift in the United States during the past 50-plus years regarding this principle. Prior to about 1960, paternalism by healthcare providers (physicians) was the way decision-making was done. Physicians decided whether patients were told certain diagnoses and pressure was put on patients to always follow designated treatments (Friedlander, 1995). This model no longer receives the same emphasis; rather, the emphasis now centers on the autonomy of the patient, and, by extension, family members. There are many variables to explain this paradigm shift: (1) a U.S. population increasingly educated about their medical conditions, (2) a changed U.S. society where Americans no longer give deference or authority to several segments of society including the medical system, (3) a changed healthcare system for which interdisciplinary collaborativeness is recognized as the key to safe patient care versus dominance by physicians, and (4) Web technology with comprehensive easy access to medical and other knowledge.

Another current example of this ethical principle of autonomy being practiced can be seen in the federal Health Insurance Portability and Accountability Act (HIPAA). One could analyze that this particular federal law has emphasized and mandated one aspect of patient autonomy (i.e., that of patient decision-making in terms of who will have access to patient information).

This third principle of autonomy also applies to the Nebraskan case study. One could argue that the autonomy of patients was not being honored. However, it was not the traditional physician who was being paternalistic; rather, it was out-of-state organizers who were being paternalistic and deciding what was best medically for a population of Nebraska state residents. Had it passed, it then would have been the state government being paternalistic in end-of-life decisions. In retrospect, a partial evaluation of why the amendment did not elicit enough signatures in Nebraska integrates with this principle and with some other aspects of the culture of Nebraskans. In the United States generally, and in some states with a strong politically conservative ideology, such as Nebraska, there is an antigovernment philosophy (i.e., wanting the least amount of governmental intrusion in one's life). Having a state law mandating

certain medical treatment would violate this Nebraskan philosophy. Another value held by Nebraskans is, if there is going to be government control, then the principle of subsidiarity should control (i.e., the government control should be as local as possible). It was definitely not perceived well by Nebraskans to have change agents from out-of-state fund and attempt to control state policy. At a state population level, Nebraskans do not like this kind of out-of-state influence and paternalism—whether it is regarding healthcare policy or other policy. Further, such out-of-state tactics are the antithesis of the singular populist history of this state. In addition to these issues, data from a 2007 survey conducted by the Nebraska Hospice & Palliative Care Organization described some of the wishes of Nebraskans relative to health care: 33 percent of Nebraskans had an advance directive, 96 percent “said it’s important to be off machines that extend life, and 74 percent wouldn’t want medical interventions to keep them alive as long as possible if they were dying” (Nebraska Hospice & Palliative Care Association “Survey Probes,” 2007). Another data point related to this Nebraskan case study is that 75 percent of Nebraskans reported they felt that total physical dependency on others would be worse than death.

Besides the ethical consideration of autonomy versus paternalism, there is a legal counterpoint to the ethical dimension of this concept. A series of lawsuits originated from the classic 1914 lawsuit *Schloendorff v. New York Hospital*, which gave legal power and authority to the individual regarding what happens to his or her body (autonomy) (Menikoff, 2001). Some of these lawsuits also related to the necessity of having informed consent between a healthcare provider and a patient. This third principle of autonomy versus paternalism is deeply rooted in both ethics and the law in this country. The proposed constitutional amendment would have contradicted the history of both ethics and law in this regard.

Nurses in the early twenty-first century recognize the autonomy of patients and family members. If the proposed amendment of the Nebraskan case study had been enacted into law, how would a Nebraska nurse work within this ethical dilemma? Suppose the nurse practices in a hospice setting, the patient has no “fully expressed” advance directive, but the family knows (from many conversations with the dying patient) that he did not want prolonged artificial hydration. What does the nurse do? Follow the law and implement the mandated policy? What about the nurse’s responsibility to follow the ethical principle of respecting the patient’s autonomy? What about the nurse’s responsibility to follow the ANA’s Code of Ethics and advocate for patients? What about the nurse’s responsibility to follow best practices?

Another ethical principle is that of justice (Purtilo, 2005), which relates to the nurse’s position (professionally and personally) whereby

the nurse has the ability to distribute benefits and burdens to individuals and to society. A beginning way to think about the justice imperative is to reflect on and evaluate one day in a clinical setting as a nurse. How did I spend my time? If I was assigned several patients, how did I spend my time? Did I spend it justly? What would be the several patients' perspectives, if questioned, of how I divided my time among them? How would I justify my time with each of them? The reader can think of many more justice issues in nursing. For example, is it just (to patients and to oneself) to continue working on a unit where there is persistent understaffing? Is it just (to patients and to oneself) to continue working in an environment where there is consistent mandatory overtime? Also, there are broader issues in the healthcare system, such as how total healthcare resources should be allocated.

There could be many ways to apply this Nebraskan case study to the ethical principle of justice, but just two will be given here. Individuals' behaviors are influenced by many laws and regulations: federal, state, county, and city. The United States—its Constitution and its laws—was forged on a balance between federal and state laws. There is a strong history of Americans wanting any law or regulation to be at the most local level versus a federal law (i.e., the concept of *subsidiarity*). Is it just for individuals outside of one state to make policy for people residing in another state? Is it just to use language—"Nebraskans for a Humane Care Amendment"—when some individuals would analyze the language as not being totally truthful? Another area of justice relates to cost. Healthcare costs have always been a significant driver of reform in the system and have affected whether many individuals seek or receive health care. Is it just, from a cost perspective, to mandate sustained hydration and nutrition for all?

In addition to analyzing ethical dilemmas based on these four principles, another model to use is the Ethics of Caring. This model of analysis builds on the work of Carol Gilligan (1982) who expanded on Lawrence Kohlberg's model of moral development of individuals, which was at the time the dominant theory for understanding this aspect of individuals. However, Gilligan, one of his graduate students, continued his research—but with girls. She noted differences in how girls, boys, women, and men conceptualized ethical dilemmas (Beauchamp & Childress, 2001; Brannigan & Boss, 2001; Purtilo, 2005). This model of ethical analysis emphasizes relationships, caring for others, listening to others' stories, and balancing justice issues with compassion. Although there is not a strict gender division, women tend to embrace a conception of considering the total context of a situation, maintaining and nurturing relationships, and being caring when considering an ethical dilemma. Men tend to evaluate ethical dilemmas more in justice terminology and with more impartial, dispassionate conflict resolution.

Because of the dominance of women in the nursing profession, the Ethic of Care is further emphasized, not only because of the numerical strength of women nurses, but also because a core essence of nursing is caring. Healthcare providers and the lay public usually associate caring with nurses and curing with physicians. In the past 25 years, many nurses have written about Gilligan's work and applied it to nursing. An important aspect of the Ethic of Caring is narrative ethics requiring "that all voices be considered before the situation is assessed for its moral significance" (Purtilo, 2005, p. 56). In the Nebraskan case study, had all voices been heard?

Nebraska Nurses Respond to the Nebraska Amendment

Nebraska nurses, in their roles as leaders, responded to the proposed petition drive that did not get on the ballot in November 2006, using the media to transmit their concerns, individual lobbying, and so forth. Amy Haddad (2006), director of the Center for Health Policy and Ethics (CHPE) at Creighton University and a nurse, wrote an editorial for the *Omaha World Herald* discussing the issue and raising concerns. For many individuals, this was the first time that concerns with the petition drive were in the public media. Because of the controversy surrounding the issue, Haddad first shared her writing with all levels of university administrators and legal counsel. Second, the Center for Health Policy and Ethics hosted a brown-bag lunch meeting on the issues the amendment raised. Invited speakers included a theology professor, an attorney, and an ethicist from the CHPE who is educated as a physician and attorney as well as an ethicist. Third, the CHPE developed a summary position statement and distributed that statement to attendees. The statement emphasized four areas of concern:

1. Decision-making would be taken from family members and given to the state unless there was a living will with specific language or an appropriate power of attorney.
2. A competent patient could not refuse treatment nor grant or withhold informed consent.
3. The amendment required a procedure that may not help a patient; rather it might cause discomfort and/or hasten death.
4. The amendment proponents presented no evidence of a current concern or problem with patients in Nebraska.

Proponents were presuming that only the use of law and potential legal punishment would assure best care at the end of life. A large group of concerned healthcare providers, other individuals, and healthcare

agencies formed a coalition to address the concerns they had with this proposed amendment. This group held many meetings, planned strategies, and educated the public. It recognized that the amendment, although not on the ballot in the fall of 2006 because of technical reasons, might be an issue again in fall 2008. One example of the kind of education and analysis the group provided was a lengthy side-by-side column analysis of current law and practice in Nebraska with provisions of the proposed amendment (R. Anderson, personal communication, September 2006). Analysis by attorney Anderson and others noted the poor legal construction of the proposed amendment because many phrases were vague, language was not defined, and many phrases were open to interpretation. Another kind of education and analysis was presented by the many nurses who participated in this coalition and who shared their clinical, theoretical, and research knowledge. Many of these nurses were hospice nurses, and their knowledge of both dying patients and the literature greatly contributed to others' understanding. In an earlier section of this chapter, it was noted that the petition group, America at Its Best, spent \$835,000 on education and lobbying of voters to get on the ballot. Education of healthcare professionals, patients, families, and voters was done on a shoestring budget by the nurses and others. As noted earlier in this chapter, the petition was not reinitiated in 2008.

Reaction to the “Out-of-State” Initiative

During spring 2007, several Nebraska state senators introduced three state laws to address concerns raised by the proposed 2006 constitutional amendment discussed in this chapter. First, Senator Ray Aguilar introduced Legislative Bill 311, which was unanimously voted out of the Government, Military and Veterans Affairs Committee (Nebraska Legislature, 2007). This bill would change provisions relating to petition signature verification and have such provisions conform to the court case of *Stenberg v. Moore*. The second bill, introduced by Senator Bill Avery, would change signature thresholds for both constitutional amendments and statutory initiatives (Nebraska Legislature, 2007). His proposed bill, which moved forward from the same unicameral legislative committee by a vote of 6–1, would increase the required number of signatures on constitutional amendments from 10 percent of the state's registered voters to 15 percent. His intent was to make it more difficult to change the state constitution. His and other senators' concerns were the issues discussed in this case study and other petition drives in Nebraska since 1990. Senator Avery said, “I also have deep respect for our state constitution. It deserves to be protected from the

desires and whims of out-of-state organizations. It's not written in pencil so that whoever has the biggest eraser can come in and erase it all willy-nilly" (Nebraska Legislature, 2007, p. 7). The third bill, introduced by Senator DiAnna Schimek, passed the first of three necessary rounds of voting in the full unicameral session by a 31–11 vote on February 1, 2007 (Reed, 2007). This bill would prohibit petition circulators from being paid per signature when they are employed for such work. Again, the origin of this bill related to the concerns and frustrations state senators and others had with the issues discussed in the Nebraska case study. Sen. John Harms's argument during the unicameral discussion was reflective of many senators: "That's what got people fired off, it was people coming here from out of state, with no idea about the issues in Nebraska. . . . It was millionaires putting money into telling Nebraskans what to do. That's wrong" (Reed, 2007, p. B2). The two bills introduced by Senators Aguilar and Schimek were passed on March 7th, 2007 and February 19th, 2008; the bill introduced by Senator Avery was indefinitely postponed on April 17, 2008. In summary, the introduction of these three state laws (with one relying on the judicial outcomes of a court case) demonstrated other important ways that legal decisions affect nursing in addition to constitutional amendments (initiation of state laws and court cases). Nurses in Nebraska were active in lobbying measures on these bills.

In the years since the stoppage of this petition, other policy activism has been occurring in Nebraska on this topic. This advocacy, titled "It's All About the Conversation," is the beginning effort of a large multidisciplinary task force of, again, interested policy activists on the issues of end-of-life care and advance care planning. However, since its beginning in April 2012, the policy dynamics have been far different than what was seen in the 2006 case study. This group was started within Nebraska, by Nebraskans, and is a group that is multidisciplinary, inclusive, and intentionally representative of any who have interests in and concerns for these aspects of the healthcare system. Some examples of policy actors are chaplains; community members; emergency medical services employees; nurses; physicians; representatives of nursing homes, long-term care settings, and hospices; and state government health and human services employees. This group met in November 2012 to forge its mission statement. It is incorporating the results of three research studies done by the Nebraska Hospice & Palliative Care Association, yet another indicator of the concern for what the population of this one Midwestern state wants for their health care at the end of life. Of special import to this chapter is that one important leadership individual in the group is an advance practice nurse implementing a policy role that the essentials document calls for. Although the three survey studies are one indicator

of ongoing interest in this aspect of the healthcare system, another indicator is the frequent use of the Physician Orders for Life-Sustaining Treatment (POLST) directives by physicians in three mid-state towns of Columbus, Kearney, and Norfolk. (H. Chapple, personal communication, November 6, 2012). The latter will be one model of end-of-life care the group will discuss. Thus, when comparing the two case studies (2006 and 2012), one of a government petition policy and one of a private sector policy, one can analyze very different traits regarding each proposed policy approach. Further, one can affirm the activism and health policy competencies of nurses in each case study to promote population health status.

Nurses must be cognizant of the many influences that affect decision-making and nurses' practice on a daily basis. This text gives the nurse insight into others' decision-making including patients, family members, healthcare providers, institutional administrators, and policy advocates. Although this chapter has focused on some policy, legal, and ethical content, the 2006 Nebraska case study demonstrated why and how easily one's clinical nursing practice can be significantly altered because of proposed policy and legal activities that may cause nurses legal, ethical, and professional difficulties. Rentmeester (2006) stated:

In negotiating uncertainties and responding to interesting, important, and complex questions and dilemmas in healthcare, it appears that healthcare professionals cannot rely solely on legal experts. Rather, they must carefully discern and collegially discuss moral reasons to respond with care to patients and to one another in difficult cases. (p. 32)

The Nebraska case study exemplifies one complex dilemma in patient care: policy, law, ethics, and nurses. They interact with each other in dramatic ways. Nurses, as leaders, need to be prepared for these challenges.

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