SECTION I

Foundations of Advanced Practice Nursing Ethics

CHAPTER 1

Philosophical Foundations of Applied and Professional Ethics

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Believe those who are seeking the truth. Doubt those who find it.

—Andre Gide,

So Be It, or, The Chips Are Down (Ainsi Soit-Il, ou, Les Jeux Sont Faits), 1959

A desire of knowledge is the natural feeling of mankind; and every human being, whose mind is not debauched, will be willing to give all that he has to get knowledge.

—Samuel Johnson,
Boswell's Life of Samuel Johnson, July 30, 1763

Introduction

For the purposes of this text, the terms *advanced practice registered nurse* (APRN) or *advanced practice nurse* (APN) are used interchangeably to denote any and all nurses who are working in expanded nursing roles. In the United States, APRN has become the preferred term and denotes the achievement of official credentials beyond registration. APN is the preferred designation internationally (ICN Nurse Practitioner/Advanced Practice Nursing Network, 2016) and may or may not signify additional credentials. However, a certain level of knowledge and skills beyond those of an entry-level nurse are implied by the term *advanced*. It includes the burgeoning numbers of nurses in the United States who have acquired or are pursuing a doctorate in nursing practice (DNP) degree.

This chapter explains that the roots and strength of advanced practice nurses' (APNs') professional responsibilities are in philosophical understandings about what constitutes good human action, why, and under which circumstances. From this foundation, it is possible to trace the development and nature of professional responsibility to the population served by the nursing profession. The origins of nursing's particular perspective and goals are highlighted. That is, the discussion in this chapter assumes that the profession offers services that are differentiated from the services of other healthcare professions even though general goals may be shared. A clear argument is presented about why membership in a profession that provides an important service to individuals and society involves stronger obligations to further the human good than exists in civilian life. Finally, an exploration of the appropriate roles of philosophical skills, theories, and principles in decision making about good action provides a basis for examining the complex issues encountered by APNs. This is an important first step for developing and enhancing APNs' confidence in their ethical decision-making skills.

Groundwork

The Problem of Professional Responsibility

Most nurses and allied health professionals understand that the privilege of professional healthcare practice is accompanied by both moral and legal accountability for professional judgments and resulting actions. However, many are not confident that they are adequately equipped to address obstacles to good practice or the complex ethical problems that can arise in direct care or supervisory situations (Grace, Robinson, Jurchak, Zollfrank, & Lee, 2014; Robinson et al., 2014). Nevertheless, good patient care requires the following essential clinician characteristics: knowledgeable, skillful, and experienced; perceptive about inadequacies in the caregiving environment; willing to focus on the individual needs of the patient in question; and motivated to resolve problems at a variety of levels as necessary. Professionals also need to recognize the limits of their knowledge and be willing to draw on the expertise of others—a type of self-reflectivity. These characteristics are important for obvious reasons and are discussed in more detail in Chapter 2. Less obvious is the idea that those in need of healthcare services are often not knowledgeable about what is required to meet their current or future health needs; they are not qualified to evaluate the quality of the services offered and/or they cannot advocate effectively to receive the care they need (Newton, 1988). Unmet or even unrecognized health needs make people more than ordinarily vulnerable to the ups and downs of life. The effects of unaddressed health needs on human functioning and flourishing make it crucial that healthcare professionals can be trusted to maintain their primary focus on individual and societal healthcare needs, even when faced with economic, institutional, or time pressures. Retaining this focus is not simple. From contemporary moral psychology literature, as well as the growing body of knowledge about moral distress, we are learning that there can be a numbing or distancing effect when one is frequently exposed to situations where one feels powerless to do the "right thing" (De Villers & DeVon, 2012).

Fiduciary Relationships

Many scholars have argued that the healthcare professional–patient relationship is fiduciary (Grace, 1998; Pellegrino, 2001; Spenceley, Reutter, & Allen, 2006; Zaner, 1991). That is, it is based on trust. People with healthcare needs are forced to rely on clinicians to understand, anticipate, and provide what is needed. Yet in questioning professionals about their responsibilities, how strong or binding these are, or about the basis for claiming that professionals are responsible for good practice, answers are varied and inconsistent; sometimes clinicians even express bewilderment that the question is being raised. Chambliss (1996), in the course of his study of nurses working in institutional settings, noted that when nurses see themselves as powerless to influence change in a setting where there are problematic practices, they can become numbed to the ethical content involved and fail to address it. Others have also documented the problems of nurses feeling powerless. In addition to ceasing to respond to unethical practices when they feel powerless, some nurses leave the setting or seek other types of employment and/or can experience lasting unease, also called *moral distress* (Corley, 2002; Corley, Minick, Elswick, & Jacobs, 2005; Gallagher, 2011; Jameton, 1984; Mohr & Mahon, 1996). Additionally, there is reason to believe that some nurses do not understand the ethical nature of daily practice (Grace, Fry, & Schultz, 2003). Thus, recognition of the fiduciary nature of practice responsibilities requires the nurse to reflect on practice in an ongoing fashion in order to avoid becoming anesthetized to recurrent problematic situations that at best fail to focus on optimal care and at worst are detrimental to patients. Moral agency represents the ability of a nurse to take appropriate action in difficult circumstances. The development of moral agency in readers is a goal of this book. Moral agency is an antidote to moral distress and its psychological and physiological effects (Grace et al., 2014; Robinson et al., 2014; Rushton, Caldwell, & Kurtz, 2016).

Throughout this text, reasoning and support are provided for the idea that professional responsibility exists to address both immediate problems and more deeply rooted systemic or societal obstacles to practice. APNs are ideally prepared and situated to see their responsibilities broadly and influence change, whether this is within their immediate environment or the social contexts of care delivery, the education and supervision of others, or empowering patients and patient populations to get their needs met. Moreover, as leaders APNs may be called upon by others to help them resolve difficult situations, including ethical issues associated with patient care.

Good Practice

From a philosophical stance, *good practice* is equivalent to ethical practice. *Ethical practice* is the use of disciplinary knowledge, skills, experience, and personal characteristics to conceptualize what is needed either at the level of the individual or of society. Ethical professional practice uses the goals and perspectives of the given profession to direct action. Although it is true that various healthcare professions share common goals, such as promotion of health, cure of disease, and relief of suffering, they nevertheless have different practice philosophies and draw on different knowledge bases to achieve these goals.

Even when professionals understand the strength of their responsibilities, many factors can interfere with accomplishing good care. This is especially true in contemporary healthcare settings, where competing interests can make it difficult to provide good patient care to individuals even when the clinician's judgment about what is needed is sound. Barriers to autonomous practice are frequently encountered and can include economic interests, institutional priorities, interpersonal communication difficulties, or provider conflicts of interest. Some obstacles to practice are recurrent and arise out of underlying contextual or societal conditions that disadvantage groups of people and thus require a broader understanding of professional responsibility in relation to individuals, institutions, and society (Ballou, 2000; Grace, 2001; Grace & Willis, 2012; Spenceley et al., 2006).

As noted, this and the next three chapters are designed to provide a firm basis for APNs, master's-level or doctor of nursing practice (DNP) nurses, and those from other countries practicing in expanded roles, to understand the origins, scope, and limits of their responsibilities to patients and society. The text provides the APN and equivalent with the knowledge, tools, and skills for ethical practice. Included in the necessary skill set is an understanding of the language of clinical ethics. This is because all nurses—but especially APNs—collaborate with others on behalf of their patients and need a common language for articulating their concerns about the ethical issues they face in practice.

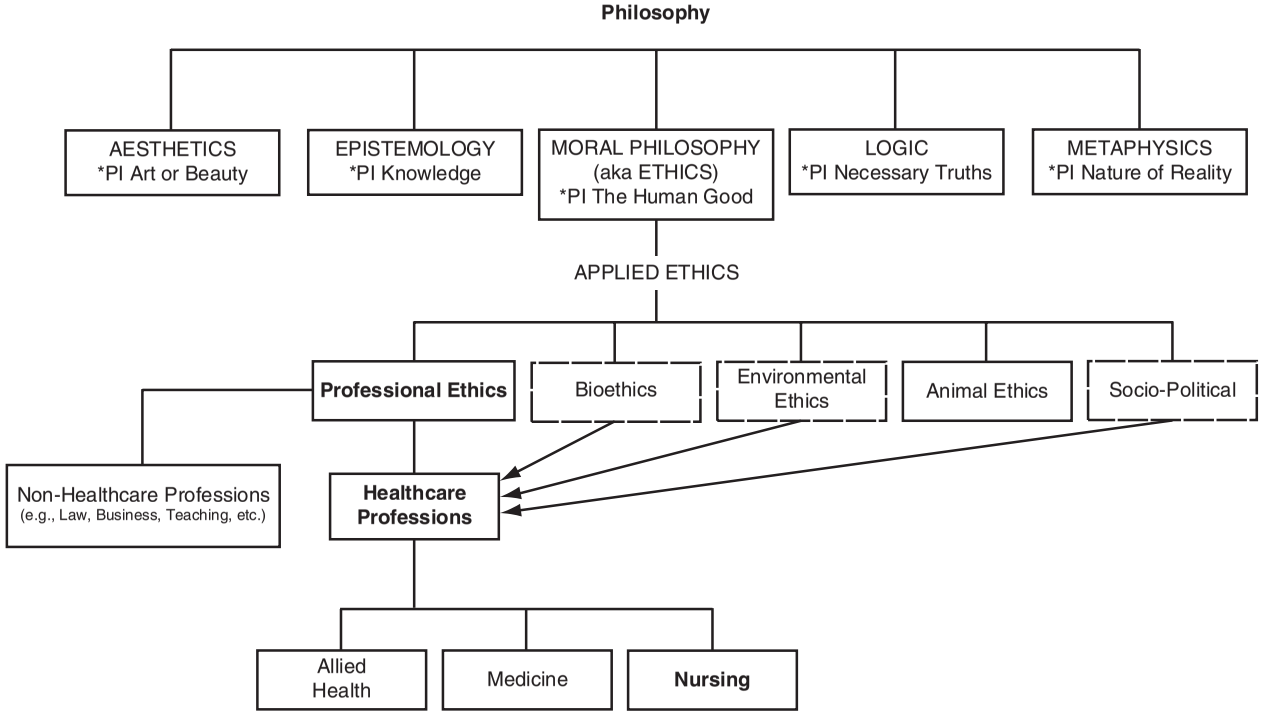
Philosophy, Professional Responsibility, and Nursing Ethics: What Is the Connection?

Nursing ethics and *professional responsibility* are equivalent concepts. However, one cannot merely say this is so and expect others to accept that premise without discussion and evidence. A technique of philosophical exploration or analysis is to examine what assumptions are being taken for granted without further questioning about whether they are true or reliable. As a starting place, it is important to grasp that the idea and possibility of ethical practice lie in philosophical understandings about human beings and their relationship to the world in which they live.

To trace from its origins in philosophy the development of the concept "professional responsibility"—that is, the idea that members of a given profession have responsibilities toward those served and that these are ethical responsibilities—it is helpful to rely on an analogy commonly seen in primary care settings: a family tree. The tree and its branches are traced here to give an overview, and then pertinent aspects are discussed in more detail. A word of caution: The branches are made distinct for the purposes of clarity, but there are often areas of overlap or shared space.

Philosophy's Family Tree

The discipline of philosophy is the starting point where all theorizing about the nature of the world and our place in it begins. There are several branches of the parent philosophy. These branches represent particular areas of philosophical inquiry: "aesthetics, ethics, epistemology, logic, and metaphysics" (Flew, 1984, p. 267), as shown in **FIGURE 1-1**. They all share some common characteristics. They all use questioning and reasoning (the methods of philosophy) to try to understand the relationship of human beings to the world. However, their themes or focuses of inquiry are different. For



*PI = Philosophical Inquiry about
Dashed-line boxes = Areas of applied ethics impacting the healthcare professions in various ways.

FIGURE 1-1 The relationship of philosophy to nursing ethics

example, *aesthetics* is philosophical inquiry about art or beauty. *Ethics* is philosophical inquiry about the good and is also called *moral philosophy* (everyday definitions of *ethics* differ from this, as discussed shortly). *Epistemology* is philosophical inquiry about knowledge: what it is, what we can know, who is the knower, how reliable is the knowledge, and for what purposes. *Ontology* is another branch of philosophy; it investigates the meaning of an entity's existence. Nursing's ontology, then, results from inquiry by nursing scholars—informed by practice environments and the needs of society—about what nursing is, what nurses do, and why nursing exists.

For present purposes, our interest is in Ethics viewed as philosophical inquiry about the good. Philosophical inquiry about what is good in human action branches further into areas of applied ethics. *Applied ethics* are the practical applications of theoretical ethics. Branches of applied ethics include *eco-* or *environmental ethics* (what is good human action with regard to the environment?), *animal ethics* (how should we treat animals and why?), *bioethics* (what are the implications of biological advances and how should they be used?), and *professional ethics* (what is the nature of a given profession's services, and what are the implications of this for those served?).

As noted earlier, there are areas of overlap. For example, bioethics is inquiry about the impact of biological and technological advances on humans and what actions are permissible, prohibited, or mandatory. Professional ethics related to healthcare professions has to do with understanding what is required for good professional action. Because healthcare professionals often use technology to provide good care, these areas overlap. A bioethical question might be "How do we decide who gets the one available heart of the four people who urgently need it?" Nursing ethics questions might be "What is my professional responsibility toward my patient whether or not he receives the heart? What is needed for his good care? How do I ensure that he gets what he needs for optimal well-being or to alleviate his suffering?" When Ethics or philosophical inquiry about good action is coupled with an area of human practice of some sort (for example, health care, business, or the law), it is called *applied ethics*. That is, theoretical understandings about what is good and/or the methods of philosophy (analysis and reasoning) are brought to bear upon a situation in order to understand as fully as possible its different aspects, including those that are not immediately apparent. Philosophical inquiry allows us to "interrogate" the situation, questioning whether there might be more involved than we had thought and providing direction for information gathering. Gaining a more nuanced grasp of a situation permits actions that are most likely to meet patient and/or healthcare environment goals.

Ethics: A Few Necessary Distinctions

For the most part, in daily life when people discuss *ethics* they mean something very different from *ethics* as the word is being used here. In common language, *ethics* can merely mean how persons act in their daily lives and whether these actions accord with community values. In professional practice, *ethics* are sets of rules or standards, developed within the profession, that guide the actions of the professionals while working in their professional capacity. The American Nurses Association's (ANA) *Code of Ethics for Nurses with Interpretive Statements* (2015) is an example of this latter meaning of *ethics*. Nursing ethics scholars have recently provided more in-depth interpretations of the Code's interpretive statements (Fowler, 2010). These senses of *ethics* might be grasped more easily if a modifying term is added. For example, *personal ethics* is related to personal conduct, *nursing ethics* is related to the conduct of nurses

as they engage in practice, *medical ethics* has to do with the conduct of physicians, and *bioethics* is concerned with the use of technological advances (and so might include a variety of health professionals, researchers, and technology professionals involved in using or propagating these).

Additionally, many people make a distinction between ethics and morals. They view *morals* as personal conduct that reflects personal values, whereas *ethics* is associated with critical reflection of those values (Weston, 2002). In fact, the root meaning of both terms is the same: "customs, mores, . . . conventions, institutions, laws" (Bahm, 1992, p. 8). For the purposes of this text—considerations of professional judgment and action—the terms *ethical* and *moral* are used interchangeably to mean those actions most likely to further the goals of the profession.

Philosophy

The term *philosophy* can be used in a variety of ways. It can simply mean a personal view of a particular thing, as in "What is your philosophy about always telling the truth?" or "What is your philosophy on balancing leisure and work?" *Philosophy* can also mean a group's view of the nature and purposes of its work; for example, there are a variety of philosophies of nursing practice. Philosophies of practice use the tools of philosophy to answer important questions about that practice. Florence Nightingale wrote hers as early as 1859 in *Notes on Nursing.* She believed that nurses attended to the patient's environment, making it conducive to natural healing. However, for the purposes of this discussion, *philosophy* means the overarching discipline, under which more specific philosophies belong.

Philosophy as a discipline encompasses the centuries-old endeavors of thinkers and scholars to find answers to the questions of existence. Philosophy, in this sense, has been concerned with a "search for wisdom about the universe and its workings," as well as the place and role of humans within the universe (Grace, 2004c, p. 280). The pre-Socratic (meaning before the time of Socrates) Greek philosophers, such as Thales, Heraclitus, and Parmenides (around the 6th century B.C.), are considered the first philosophers (Russell, 1972). It is thought that before this time people relied on mythological explanations for the mysterious and seemingly unpredictable workings of nature. The pre-Socratics, however, sought explanations using reason and observation.

For the purposes of this discussion, the discipline of philosophy uses reason and analysis to examine questions that are not answerable or not completely answerable by empirical science. As Nagel (1987) noted, "The main concern of philosophy is to question and understand very common ideas that all of us use every day" (p. 5) but often without giving much thought to their meanings. As an example, empirical science investigates the causes and effects of heart disease in the interests of both prevention and cures. Philosophical inquiry, however, would be concerned with questions such as "Is it possible to have a stable definition of *health*? Is health measurable?" If the answer to the question of "What is health?" is at all dependent on a subjective interpretation by a given individual, then it is not measurable by science. We can measure people's *perception* of how healthy they are, perhaps, but this will not define health.

Another way to look at this is to say philosophical inquiry highlights what cannot be true but does not necessarily give us truths. In fact, one major question of philosophy is "What is truth?" The main methods of philosophy are thinking and questioning. Reason is used to formulate and pose questions, seek out and examine

possible answers, anticipate what objections could be made to the answers, or question whether counterexamples exist that would reveal a theory to be false. Philosophy also helps in understanding the limits of our knowledge.

The discipline of philosophy, then, can be seen to be the enterprise of inquiry itself. The major subareas of philosophical inquiry were presented earlier. The branch of philosophy most pertinent to the current discussion of healthcare professional responsibility is that of moral philosophy, also known as Ethics. From now on, when referring to that branch of philosophical inquiry that is concerned with human good, the terms *moral philosophy* or *Ethics* with a capital "E" will be used to distinguish it from the definition of ethics as rules or standards for action.

Moral Philosophy: The Study of Ethics

Ethics, as a term used to describe the area of philosophical inquiry concerned with what it means to say something is good, bad, or neutral in human activity, is also often referred to as *moral philosophy.* As explained earlier, this is a different view of ethics from that apparent in the use of the term in everyday language. Philosophical inquiry is a theoretical endeavor; therefore, Ethics is also a theoretical endeavor. Ethics or moral philosophy is concerned with understanding human values. In fact, moral philosophy as a field of study often leads to the development of theories of value.

Value theories, often also called *moral theories,* try to answer such questions as "What do we mean when we say something is good, bad, praiseworthy, or blameworthy? What makes something, someone, or some action good or bad? Is something good because it is in line with divinely given rules using certain people as intermediaries (for example, Moses and the 10 commandments), or because it helps humans live a satisfying life? Are qualities of goodness and badness inherent in human nature? Are there some things that are absolutely right or wrong? Or are the understandings we have about right and wrong, good and bad, just conventions developed over the years to make it easier for humans to live in relative harmony with others?" Moral philosophers have different answers to these questions. The answers they give are meticulously thought through and provide important insights into the meaning and purposes of human life. It is, however, important to remember that these insights are always necessarily influenced by the lives and political times in which the philosophers engaged in their analyses, as well as by the philosophers' conscious or unconscious motivations for trying to make sense of the world. Different theories can give conflicting directions related to a given situation depending on their premises and assumptions; thus, what is a good action according to one theory might be seen as not permissible using a different theory. Moral theories, then, are not capable of giving concrete direction in healthcare settings, because they are mostly theories about the conditions of living together within a society. Moreover, different moral theories give different answers to complex problems. Thus, what is considered "right" depends on which fundamental underlying premise is relied on to assert what is good for humans to strive for and why. In health care, however, the goal is to further the health and well-being of given persons or populations in the context of a particular goal. Moral theories serve to help explain the possible "considerations." They can provide clarity about a given situation, but they *cannot* provide definitive answers. It might be desirable to have the comfort of relying on a particular theory for ethical decision making, but theories cannot serve this function. The following paragraphs are some examples of moral theories, along with critiques of their roles and limits in healthcare decision making.

Applied Ethics

As noted, the term *moral philosophy* is synonymous with Ethics viewed as a theoretical endeavor—the larger sense of ethics. When philosophical and theoretical concepts, suppositions, and skills are applied to practices or human action, the tendency is to refer to this as applied ethics rather than applied moral philosophy, although there is no particular reason for this—it is simply a convention. Applied ethics uses the theoretical knowledge and assumptions gained as a result of ethical theorizing, as well as the skills and tools of moral philosophy (analysis), to solve difficult problems of living. *Applied ethics,* as its name implies, is the application of moral philosophy to actual situations where it is important to determine good or appropriate actions and where a person or group can be held responsible for these actions. Thus, branches of applied ethics are many and varied and include such entities as ecoethics (good human actions related to the ecosystem), animal ethics, bioethics, and professional ethics.

The appropriate ethical conduct of a profession such as nursing is determined by a synthesis of philosophical inquiry about the ontology of the profession (what nursing is, why it exists, and what its goals are), what constitutes good practice for the discipline (moral philosophy), and what is the force of the responsibility of the profession, both as an organized body and via its individual members, to engage in actions that further its goals (applied or practice ethics). The result of this synthesis is *Nursing Ethics*. Nursing Ethics is an applied ethics. It is the study of what constitutes good nursing practice, what obstacles to good nursing practice exist, and what the responsibilities of nurses are related to their professional conduct. Nursing Ethics can be exploratory (inquiry), descriptive (empirical), or normative (also called prescriptive). These distinctions and their importance are discussed in detail in later chapters.

Moral Reasoning in Health Care: Tools

"Ethics as a field of inquiry studies the foundation for distinguishing good from bad and right from wrong in human action" (Grace, 2004a, pp. 299–300). "The theoretical interest is concerned with knowing; the practical interest is concerned with doing" (Melden, 1967, p. 2). Thus, moral reasoning in health care uses theoretical understandings, reasoned assumptions, and proposals about what is the good for humans and applies these theoretical explanations to problematic or complex situations where it is not clear what actions should be taken. In addition to the tools of philosophy, personal characteristics and abilities are needed to apply theory to particular cases. The purpose of this section is to describe the scope and limits of various philosophical approaches in resolving ethical issues in healthcare settings. This section is designed to familiarize APNs with the language and techniques of ethics in the interest of facilitating communication and collaboration on behalf of their patients or patient groups. It can be daunting to encounter and negotiate some of the language and concepts discussed, but over the course of the book the reader will become more familiar and comfortable with them.

An important point that is emphasized throughout is that nursing goals serve as the linchpin for decision making and are related to different aspects of promoting health and human functioning as determined by the specialty practice focus and/or the leadership, supervisory, educational, and policy roles of the DNP, nurse practitioner (NP),

clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), or expanded nursing role as these are delineated in other countries. The tools of applied ethics, then, facilitate an understanding of what is required to promote professional goals. In this sense, the question, "What is the good?" has already been answered by nursing's scholars and theorists. Unlike the larger unanswered or unanswerable philosophical question "What is the ultimate good for human beings?," the nursing profession has an answer related to its practice and existence. Nurse scholars and practitioners have determined what constitutes the profession's good.

The four main types of philosophical tools that apply to morally ambiguous healthcare situations are moral theories, moral perspectives, moral principles, and analytic techniques. Additionally, skills of mediation are increasingly recognized as a way to keep moral spaces open (Blackall, Simms, & Green, 2009; Dubler & Liebman, 2011; Fiester, 2012; Walker, 1993). That is, mediation allows the voices of everyone involved to be heard in as unbiased and neutral a fashion as is possible and in the interest of a mutually satisfactory resolution. An extensive discussion of ethical theory and principles is not possible (or desirable) here; whole books are devoted to any one of the theories or principles, and further books are dedicated to the critiques of these. However, a comprehensive summary of those aspects of previous work in moral theory that are important for our contemporary understanding of moral authority and responsibility follows.

Moral Theory

What is moral theory? The simple answer is that it is a systematic justified explanation of what good means in terms of how human beings *do* or *should* seek to live their lives. That is, it may be either a descriptive (this is what people do or seem to believe) or prescriptive theory (this is what people *should do* if the precepts and assumptions of the theory are right). The author of the theory has tried to formulate an answer to the unsolved question "What is the meaning of good as it relates to human lives and human living?" The theorist, using reasoning, observation, and questioning, formulates a hypothesis and systematically justifies it, all the while trying to anticipate and address possible objections that could be raised by critics of the theory or by those holding different views. Because one of the tasks of philosophy is to show what cannot logically be true (the logic branch of philosophy), every moral theory has many philosopher critics.

Theorizing about human lives and the nature of good has been a human pursuit since the times of the ancient Greek philosophers such as Socrates (circa 450 B.C.), Plato, and Aristotle. There has been an ongoing quest to find systematic explanations and/or unchangeable, irrefutable truths about what is valuable in human lives. One reason this has been seen as important is the human desire for stability, the need to dispel uncertainty about action, and also the need for clarity and direction about how people should live. As stated earlier, moral theory may sometimes be referred to as value theory because its subject matter has to do with what is taken to be valuable, or what should be valued. That is, if it is possible to know what is good for humans to pursue, what sorts of lives are good to live, and which human characteristics are good to develop, and humans have sound reasoning, then society can feel it has a relatively firm footing from which to move forward.

There Is No Theoretical Agreement About the Ultimate Good

No theorist, however, has found a flawless answer to the question "What is good?," nor have any developed theories that can completely withstand critique. Contemporary thinkers argue that this quest to find the highest good for human beings, or in Latin the *summun bonum*, is misbegotten. In fact, Dewey (1980), a philosopher of the American Pragmatist School, noted the reason that philosophers have struggled so hard and long for answers is that "man who lives in a world of hazards is compelled to seek for security" (p. 3), but the nature of human life is such that it cannot be found. Thus, a paradox exists.

When relatively cohesive theories have been proposed, they often made sense because of the contexts and time periods in which the particular philosopher lived, but these same theories may not remain relevant in current times or may not be relevant in all situations. Additionally, moral theories for the most part come up with different answers to similar questions, as noted earlier.

> The ultimate "good" for persons (or that which persons should or do strive for as an end in itself) has been conceptualized variously as happiness (Bentham, 1789/1967; Mill, 1863/1967), duty (Kant, 1785/1967; Ross, 1930), the cultivation of virtue (Aristotle, trans. 1967; MacIntyre, 1984), or something else. This variation is the result of fundamentally contrasting beliefs about the nature of human beings and their place and purpose in the world. (Grace, 2004a, p. 299)

Thus, it is not surprising that there will be many different answers to the hard questions of life. I do not devote significant time here to discussing the different moral theories, because healthcare professionals (including clinical ethicists) do not tend to rely on one or another of them in clinical or healthcare settings—although, from my experiences in teaching ethics, it is evident that people often *want* to use a moral theory to frame a question or justify action. This desire arguably stems from the mistaken idea that theories such as utility or Kantian deontology are authoritative; there is security in "right" answers and "right" actions. However, people can only ever at best be *reasonably* sure that their actions will have good consequences.

Moral theories can be useful in clarifying an issue or highlighting underlying assumptions. They may provide the structure with which to examine an issue, but nurses (especially APNs) must always be clear about why they think a theoretical perspective is pertinent to use for the task at hand. That is, it is necessary to understand the limits of the theory and what its flaws are, rather than uncritically relying on theories to answer difficult issues in health care.

More frequently, people use ideas from an assortment of moral theories to help clarify their thinking. These ideas are referred to as *principles*. Principles that are particularly pertinent to use in health settings are discussed shortly. However, as noted earlier, the goals of decision making in advanced practice situations are usually concerned with the well-being of a patient, or patient group, directly in the APN's sphere of practice. This is true even when APNs are in supervisory, collaborative, or consultative relationships with other providers: decisions are ultimately being made with the interests of the patient in mind. Finally, the tools of moral reasoning also prompt APNs to ask questions about underlying conditions that give rise to the

problems in front of them and help APNs to recognize the wide scope of professional responsibilities.

Descriptive Versus Normative Theories

Moral theories such as David Hume's (1777/1967) are based on observations of what people seem to believe with regard to good actions and what reasons they give for their decisions or actions. Such theories do not prescribe what people ought to do. They are observational and explanatory rather than having any moral force. They make no claims about the existence of some universal underlying purpose that human beings should strive to fulfill, but rather aim to describe human action. Over the past few decades, a number of research studies have looked at how nurses practice, what they think is good care, what characteristics are important, and/or how they address obstacles (Corley et al., 2005; Doane, Pauly, Brown, & McPherson, 2004; Goethals, Gastmans, & de Casterlé, 2010; Hardingham, 2004; Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkle, 2011; Peter, Lunardi, & Macfarland, 2004; Poikkeus, Numminen, Suhonen, & Leino-Kilpi, 2014; Varcoe et al., 2004). These result in *descriptive* conceptions of ethical practice. That is, they do not say what is right or wrong, but rather what people think is right and wrong and the reasons they give for their actions.

Normative theories, in contrast, direct action. "They are either reasoned and logically explored explanations of the moral purpose of human interactions, or they are divinely revealed truths about good action (religious ethics)" (Grace, 2005, p. 102). Essentially they argue that because this or that is the ultimate good for human beings, then humans should pursue that good; there is a responsibility to do so. For example, although the ANA's *Code of Ethics for Nurses with Interpretive Statements* (2015) is not a theory as such, it is a normative document. It tells nurses how they ought to practice and what their behavior or conduct should be. It has moral force.

Normative Moral Theories: Some Examples

Two types of normative moral theory familiar to most people are (1) consequentialist, that is, good consequences are the focus of action; and (2) duty based or deontological, where what matters more than actual consequences is that a person acts according to his or her duty. Perhaps the best known consequentialist theories are those of the utilitarians. Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873) both were instrumental in the development of utilitarianism. Both were social reformers reacting to the injustices of the time period in which they lived. The Industrial Revolution, which started around 1760 according to Ashton (1961/1997), caused oppression of the new working classes and mass poverty; it resulted in vast inequities in wealth. A few industrialists held all the power and wealth (Engels, 1845/1987).

Bentham was heavily influenced by Hume's descriptive moral theory, which proposed that most human values are socially constructed and stem both from intrinsic human characteristics such as the ability to sympathize with others and the pleasurable effects of benevolent acts as enacted, experienced, or observed (this is a greatly simplified explanation of Hume's work). Hume is credited with introducing the idea of a utility principle into the English language. It represents the idea that human responses are fortified in relation to perception of the usefulness of their actions to others and the pleasure gained from this (Hume, 1748/1963).

Bentham, a peer and friend of John Stuart Mill's father, James Mill, further developed the principle of utility, presenting it as one having moral force. That is, if it is true that humans desire happiness and shun pain and suffering, then that is the good toward which human beings *should* strive. Giving these ideas moral force allowed the social reformers to criticize inequities caused by the Industrial Revolution and to push for reform. Many reforms, "legal, political, social, and educational" (Flew, 1984, p. 41), did occur as a result of utilitarian ideas. As Melden (1967) notes, "Hume's principle of Utility was transformed [by Bentham] with unwavering consistency into 'the greatest happiness principle'" (p. 367).

Following Bentham, Mill (1861/1965) wrote that "pleasure and freedom from pain are the only things desirable as ends . . . all other desirable things (which are as numerous in the utilitarian as in any other scheme) are desirable either for the pleasure inherent in themselves, or as a means to the promotion of pleasure and the preventions of pain" (p. 281). Pleasure was characterized as qualitative in nature in Mill's view, so he distinguished between mere physical pleasures and higher-level intellectual ones. Further, in his view the goals of action were to maximize overall happiness for a society and minimize overall pain or suffering. Each person's happiness is equally important; in this sense, the theory presents an impartial view. "Because of their focus on overall good, there are implications to these theories that many would find troubling" (Grace, 2004a, p. 300) and not in tune with common intuitions about good actions. For example, according to this approach, it would be permissible to cause harm to one innocent person if it would relieve 100 other sufferers from pain. However, when any one person becomes a means to achieving the good of another or others, all persons are in danger of becoming that person whose worth is being discounted. There are other critiques of utilitarianism, but the most salient for the purposes of this text is that APNs are interested in the well-being of each patient, and this requires understanding who the patient is. Context and details, the "*who*" of nurses' patients, are important. Utilitarian considerations might require nurses to ignore individual details, deferring to an obligation to provide an overall good. Nevertheless, in social policy and justice settings, the ideas behind utilitarianism are important. People do not tend to think that social arrangements need benefit only a few when the majority is living in poverty. In healthcare settings, APNs obviously do think that the possible consequences of their actions are crucial considerations in planning actions. However, particular consequentialist theories do not provide a stable framework for APNs because of their flaws.

Deontologic or duty-based theories are also unsuitable as blanket frameworks for decision making in health care. Immanuel Kant's (1724–1804) moral philosophy is deontologic. It focuses on the idea that something other than consequences is the most important consideration in decision making. That something is *duty*. The main philosophical assumption underlying Kant's (1785/1967) theory is that human beings are rational animals. Humans have the ability to reason and therefore the capacity for self-governance. Indeed, "the hallmark of human beings is their innate reasoning ability" (Grace, 2004a, p. 300). Because humans have this capacity, Kant went further to say that people have a duty to do the action that their reason tells them is the most rational. How do we do this? We ask ourselves whether in all similar circumstances we would agree that people could act in the same way that we are proposing to act and whether we would be willing to support a rule to this effect. If the answer is yes, then it is permissible to act in this way. If the answer is no, then duty forbids the action. Duty forbids us because it would be irrational for us to act in a way that we would not

wish others to act. Kant called this principle the Categorical Imperative because it is unwavering in its moral force. People must act from duty, regardless of consequences. For Kant, interestingly, it was this capacity of human beings to determine right from wrong actions that made them, in his eyes, worthy of respect as individuals; this capacity underlies the principle of autonomy, which will be discussed in more detail shortly.

Other versions of duty-based theories are derived from religious traditions. Kant's exquisitely argued and detailed theorizing was an attempt to avoid the criticisms leveled at religious theories by basing the idea of moral duties on the human capacity to reason. For Kant (1785/1967), then, there were absolute rules, such as truthfulness. He wrote that deviating from the truth even when it might not be convenient is irrational, because if people cannot rely on the sincerity of others with whom they are conversing, then meaningful communication becomes impossible. Interestingly, Kant did not think that women and children had the same capacity for reasoning as men.

Criticisms of duty-based theories include: (1) The rules are too abstract to apply in practice; for example, how specific should we be in determining whether a situation is similar to another? What is truth telling, and does it include withholding information that might be unpleasant to us and yet not necessary for us to know? (2) What if telling the truth might cause harm to another? Yet reason (Categorical Imperative) dictates that people should not harm each other. How do people decide between equally compelling duties?

Ethical Principles

It is clear that although moral theories exist as attempts to describe how human beings act or propose how human beings should act, and additionally provide justification for the soundness of the theory, they should not be treated as authoritative frameworks for action in healthcare settings. Nevertheless, they do provide some important insights about human values and characteristics: utilitarianism for its ability to critique social injustices, and deontology for its implications that there are general rules that all people can rationally agree on.

The APN's job is to determine both what are good professional actions in situations that require attention to nuance and particularities and what is needed to identify and address more entrenched problems related to inadequacies in the healthcare system. A key point is that certain principles derived from moral theories, together with analytic philosophical techniques, have proved helpful in healthcare settings for separating out aspects of complex situations, illuminating hidden assumptions and factors, and revealing gaps in information. Also, these are helpful in assisting clinicians as they reflect on why they feel uneasy about certain situations. It is important for collaboration and communication that the implications of certain principles are understood. Yet there is often confusion about the origins, definition, and implications of a given ethical principle. The next section explores some important principles in a little more depth, and in later chapters the principles are discussed relative to specialty practice problems.

Ethical principles are rules, standards, or guidelines for action that are derived from theoretical propositions (different moral theories) about what is good for humans. Important principles emerge over time as their usefulness in imposing order on a situation, highlighting important considerations in solving complex issues, locating the proper object of decision making, or enhancing social harmony is realized. They reflect philosophical, cultural, religious, and societal beliefs about what is valuable.

Thus, what are considered priority principles in one society may not be taken as important in another society. In Western cultures, particularly in relation to problems of healthcare delivery, several principles have retained importance over the last few decades. The most prominent examples of Western principles that are pertinent to healthcare settings have been explored and described in detail by Beauchamp and Childress (2009) and include autonomy, nonmaleficence, beneficence, and justice. These "four clusters of principles derive from considered judgments in the common morality and professional traditions in healthcare" (p. 25). APNs are charged with determining which, if any, apply in a given situation and whether clarity or insights about a dilemma or ethical issue can be gained by using these principles to explore the problem. Put another way, in healthcare practice professional judgment is still needed to determine whether a given principle applies and, if it does, how it will be honored. For example, most people understand that respect for another's autonomy is an important ethical principle, and that, all things being equal, this respect is likely to serve another's good. However, if the issue that the APN encounters is related to an incompetent colleague, then the pertinent principle to use as a guide is nonmaleficence (or how to prevent a patient from being harmed by an incompetent colleague).

In nursing practice, advocacy, caring, engagement with the patient, and knowing the patient within his or her context are also important principles derived from the profession's philosophies of practice, goals, and the roles of nurses. These principles are explored further in Chapter 2.

Usefulness and Limits of Ethical Principles

Ethical principles are useful in helping APNs identify salient issues, clarify important factors, uncover hidden assumptions, and affirm appropriate actions. However, the goals of nursing drive the principles used rather than the other way around. For example, the principle of beneficence (in general) exhorts APNs to provide a good, but the goals of nursing describe what that good is (e.g., promotion of health or relief of suffering), and nursing knowledge, skills, and experience provide the recipe for achieving the good. Motivation provides the impetus for action.

It is critical to understand that principles alone cannot solve healthcare problems, because two or more principles pertinent to a situation can give conflicting direction. Additionally, principles tend to be too abstract and nonspecific to be practical. For example, no one is ever completely autonomous; everyone is influenced by conscious and unconsciously experienced pressures: so, what degree of autonomy is acceptable and how is this determined? Principles are not always sensitive to context. For example, what does *autonomous choice* mean when the patient is from a culture where family, not individual, decision making is the norm, or when a controlling relative is pressuring the patient? Finally, human decision making and the actions that flow from this process involve conscious and subconscious values and emotions as well as reasoning, so these are also considerations. In the next few paragraphs, the four major principles highlighted by Beauchamp and Childress (2013) are explored in more detail, as are other perspectives that serve as useful tools in clinical and practice ethics. Beauchamp and Childress's book is recommended for those who want to delve in some depth into a detailed analysis of the implications of these principles and their use in healthcare decision making. However, the unquestioning use of principles to analyze everyday as well as dilemmatic ethical issues in healthcare practice has been criticized by many ethicists as not giving a full enough picture of the issues at hand

(Clouser & Gert, 1990; Engelhardt, 1996; Evans, 2000; Fiester, 2007; Gert, Culver, & Clouser, 2006; Macklin, 2003). Fiester (2007) argues that "the Principlist Paradigm is a tool that can only flag certain types of issues and considerations as morally salient in a case, and it leaves many others undetected" (p. 688). The next section highlights both helpful and problematic aspects of these principles when used in nursing or healthcare practice settings. Other philosophical perspectives that can aid APNs in solving practice problems include feminist ethics, caring ethics, narrative ethics, and virtue ethics. These approaches can remind APNs to ask questions of the situations that permit the uncovering of hidden aspects. In later chapters, such concepts are illustrated in the specialty cases and case analyses.

The Principle of Autonomy

Although people have a tendency to think they know what "autonomy" means, it is not as simple a concept as might be supposed. *Autonomy* is a term that is susceptible to a variety of interpretations. The word comes from Greek and literally means self-rule. It was originally used to describe the nature of governance in Hellenic cities (Beauchamp & Childress, 2009) rather than to describe individual capacities or rights. Subsequent understandings of autonomy are related to persons as individuals. Among the various meanings are self-determination, independence, freedom of the will, and a person's ability to regulate personal conduct using reason. It has become one of the more powerful moral principles in framing Western social and political systems and underlies ideas of universal human rights.

Because all of these different if overlapping meanings exist, it is important that clinicians clarify what definition of *autonomy* they are using when engaged in collaborative discussions or when presenting a patient's point of view. Transparency is necessary to avoid miscommunication. There are two main senses of the term *autonomy* as it is used in healthcare settings. In the first sense, autonomy means an attitude of respect for each person regardless of who they are, where they come from, or what they have done. As discussed in later chapters, this attitude is not always easy to maintain and requires being mindful of our prejudices. The principle charges people to respect every other person as equally worthy of moral concern, simply because that person is a human being, and regardless of what the person has done or is thought to have done or what we think of that person. This principle is justified by several different philosophical and theological arguments. It is beyond the purposes of this text to detail each argument, but for the interested reader the latest edition, or any of the prior editions, of Beauchamp and Childress's *Principles of Biomedical Ethics* (2013) is an excellent resource providing in-depth analyses of ethical principles. However, one branch of arguments asserts that the individual importance of human beings is derived from a divine, God-given or innate purpose. A second, more secular, string of arguments posits that all human beings share interests in being alive and flourishing, and thus all have a right to expect equal moral treatment. When individuals or groups of individuals are treated differently from others, it actually puts all persons at risk. The risk is that a change in societal attitudes can lead to individuals or groups being treated as less than fully human, which in turn lessens the prohibition against being treated as a means to someone else's ends. For example, slavery treated a whole group as if it did not warrant the same respect as other groups of persons; slaves were a means to the economic and agricultural ends of the slave owners and possessed no individual rights. Autonomy as respect for persons, then, means that regardless of

socioeconomic status, intellect, or other distinguishing characteristics, each person should receive the same sorts of consideration accorded to others.

In the second sense, autonomy is the right to make personal decisions; historical arguments for this are based on the idea that human beings have the ability to reason and decide for themselves what actions are best, whether on behalf of themselves or in interactions with others. In current healthcare practice, the recognition that patients have rights to self-determine both acceptable treatment and with whom information may be shared is derived from the ethical principle of autonomy. However, autonomy is often interpreted by nurses and others as the right to make bad healthcare decisions. This is a distorted view of the concept and its use in healthcare settings. Honoring autonomy means the professional is responsible for evaluating what the person needs in the way of information and assisting the person to interpret all available knowledge in light of his or her own projects and desires. What is meant by this is exemplified in ensuing chapters. Additionally, the principle of autonomy is sometimes invoked as the right of a surrogate to make decisions for an incapacitated person or children who have not reached a level of cognitive maturity sufficient to make informed decisions; this, however, is not a valid way to use the term.

Philosophical Theories of Autonomy. Immanuel Kant (1724–1804) is perhaps the best known proponent of autonomy as a moral principle. He wrote that because human beings have the capacity to reason, decide, and act, they should be free from the interference of others, at least as far as personal decision making is concerned. Moreover, "reason is the ruler of our will" (Kant, 1785/1967, p. 322). Our will is good in and of itself. This was evident to Kant because of "the common idea of duty and moral laws" that is evident in social life (p. 319). Kant gave the example that people know lying is wrong—they can reason this out for themselves—because lying works against social interests in being able to communicate and interact. Thus, it was self-evident to Kant that morality is an a priori condition, inherent in people. What he meant by this is that human beings are born with a capacity (and therefore are purposed) to determine what are moral actions and to carry these out. Kant believed that because man has the inherent capacity for moral decision making, he should never be used as a means to an end but always respected as having dignity and being equally worthy of moral consideration as any other man. As previously mentioned, Kant did not view women and children as having the same capacity to reason as men.

For Kant, there were two aspects to autonomy. Men, at least, are (1) capable of making their own decisions using reason, and (2) have the inherent structure to permit them to act morally (create moral rules) using the Categorical Imperative described earlier. Like Kant, "John Stuart Mill also argued that human beings—women included—have the capacity and the right to make their own decisions" (Grace, 2004b, p. 33). For Mill, diversity and creativity were to be welcomed. Freedom, he believed, is in the interests of society—it allows people to flourish and makes for better societies. Indeed, for Mill the only conditions under which it was permissible to interfere with the actions of persons was when their actions posed a serious threat of harm to another person, including restricting the other person's freedom. Mill did not believe that restricting an individual's actions for that person's own good was permissible. In healthcare settings, both theoretically and ideally, the proscription against overriding the autonomy of another cannot and does not go to this extreme. There are occasions when the ethical action is to stop a person who is at risk for serious harm

from an action, at least until the APN can determine whether the person's act is informed, reasonable, and in line with his or her own values and preferences. Whether in actuality the APN always intervenes when there is ambiguity about a patient's decision-making capacity is a different issue that is discussed later in this book, in relation to obstacles to good practice.

Contemporarily, there is agreement among moral philosophers that the reasoning process of human beings is never completely free from the influence of such things as culturally determined beliefs, emotions, lack of information, or other environmental conditions (Grace, 2004c). Autonomy is always a "more or less" condition: the more powerful and complex the influences we are subjected to, the less likely we are to be able to exercise our autonomy effectively. Decisions may seem to be autonomous when in actuality they are heavily influenced by overt or hidden influences. Recent research in cognitive, behavioral, and moral psychology highlights a more powerful role of subconscious mechanisms than previously recognized and accounted for in moral decision making (Doris, 2010; Eagleman, 2011; Kahneman, 2011). All people suffer from cognitive biases that prevent them from thinking as logically as they think they do (Kahneman, 2011). Therefore, people do not possess even the potential for the sort of detached reasoning that Kant theorized was inherent to human nature. People are more or less capable of logical reasoning, but never have absolute freedom to exercise reasoning that is divorced from unconscious, emotional, or powerful external influences.

Nevertheless, it is generally accepted that most people know themselves and their preferences better than other people can, and thus given certain conditions they have the right to exercise this freedom without interference. After all, they will live with the consequences of the decisions made. Indeed, this moral right has been recognized legally by way of the Patient Self-Determination Act of 1991 (PSDA) in the United States and is acknowledged as a moral right in many other countries (European Patients' Forum, 2009). Patients have the right to decide whether they will accept or refuse health care, including treatment and interventions. The PSDA as well as European patient rights guidelines and those of other countries are discussed in later chapters. It is important to note that many follow the prescriptions of the Universal Declaration of Human Rights adopted by member states of the United Nations in 1948.

Two questions related to autonomy in either sense—respect for persons or the right to make one's own decisions—arise here. First, and in addition to the possibility of overt and hidden influences on decision making, some people are not capable of autonomous decision making because they lack either the developmental or cognitive skills necessary. This lack may be temporary or permanent. What is the responsibility of healthcare professionals in such cases? The short answer is that where possible, a healthcare provider's responsibility is to try to discover what is known about the person and what his or her wishes would most likely be, so that actions are still based on the particular individual's preferences and the way that person has lived his or her life. However, in cases where health professionals are not able to determine what a person would have wanted, the *reasonable person* standard can be used. The healthcare provider tries, as a proxy, to decide what a reasonable person would want under similar circumstances. This issue of proxy decision makers is discussed in later chapters and also as related to specialty practice. Proxy decision makers are not making autonomous decisions in the sense of autonomy discussed earlier, however. The decisions they make are on behalf of another, not themselves. Proxy or substitute decision makers are, nevertheless, supposed to support the autonomy of their wards by representing as accurately as possible what the ward would likely want.

The second question relates to the shifting nature of factors influencing the exercise of autonomy. This is often also referred to as *decision-making capacity*. For APNs, related questions are: (1) How do we decide when and under what circumstances a person might be deemed capable of autonomous decision making? and (2) What is necessary to facilitate autonomous decision making? Criteria have been proposed that facilitate judgments about whether a person has sufficient decision-making capacity to make a decision that is likely to serve his or her interests. These criteria present their own challenges, but they do provide a framework for judging and thus for addressing impediments to decision making.

Using the pertinent literature, commission members' expertise, and discussions, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982) formulated a minimum set of capacities needed for competent decision making. These are:

- Possession of a set of values and goals
- The ability to communicate and to understand information
- The ability to reason and deliberate about one's choice (President's Commission, 1982, p. 57)

This means that, for a voluntary choice to be made, professionals need to evaluate the cognitive maturity and abilities of the person. They must assess what information the person needs and how best to provide this; thus, a process of informing (rather than a singular presentation of information) is often needed. An evaluation of influences that might interfere with information processing is important. Interfering influences could include any of the following: unconscious or conscious psychological pressures; physiologic factors such as hypoxia, fever, or pain; or contextual issues such as economics (personal and institutional), provider pressures, or wishing to please a provider. Finally, the patient should be able to describe how a given course of action is likely to map on to his or her own life trajectory.

Perhaps the most important thing to understand is that patients who obviously do not grasp the implications of proposed actions for their own goals and future life are not in a position to act autonomously. Thus, respecting autonomy in health care does not simply mean letting a patient make his or her own mistakes. Finally, in respecting autonomy there is a tendency not to interfere with people's decisions if providers are sure these are informed and/or if the risks are low. However, if the risks of a proposed course of action chosen by a patient are high, then providers must make a more concerted effort to ensure that these are autonomous decisions. Overriding a person's autonomy is a serious business but is sometimes necessary to serve the patient's interests. The rationale for overriding a patient's decision is that this is most likely to serve the patient's own interests and preserve autonomy (if the person dies, then no further autonomy is possible in this life anyway).

The Principle of Nonmaleficence

Of the ethical principle nonmaleficence, Beauchamp and Childress (2009) note that "in medical ethics it has been closely associated with the maxim *primum non nocere:* 'Above all [or first] do no harm'" (p. 149). Some scholars have said that nonmaleficence means to do no *intentional* harm. In healthcare practice, and especially in APN practice settings, nonmaleficence is a nuanced principle with several implications. Some scholars treat nonmaleficence as a subcategory of beneficence (the obligation

to do good or provide a good). However, exploring it separately facilitates conceptual clarity. Moreover, healthcare professionals, by virtue of their interventional and therapeutic roles, are often in a position to cause harm in the course of attending to a patient's needs. First, what is meant by *harm*? Does psychological, spiritual, or economic distress count as harm, or does only physical distress count? Beauchamp and Childress (2009) construe harm as "thwarting, defeating, or setting back some party's interests. . . . [A] *harmful action* by one party may not be wrong or unjustified (*on balance), although acts of harming in general are prima facie wrong*" (italics as in the original; p. 152). *Prima facie* means on first sight. Thus, harms that are generally forbidden may occasionally be justified. In civilian life, this means a robber may be harmed by incarceration, but this harm is justified by the wrong actions of the robber and the robber's infringement on the rights of another. In healthcare settings, harms are not justifiable unless they set back the patient's interests temporarily in order to provide a longer-term benefit. For example, inserting an intravenous catheter to provide fluids and antibiotics to someone in septic shock may be permissible even if the patient objects, because not doing so risks irreversible damage, and in this situation APNs do not have time to evaluate the person's decision-making capacity.

For the purposes of this discussion, it is best to think of *harm* as either any avoidable distress caused to the patient in the course of providing care, or avoidable distress that is observed by the professional and/or experienced by the patient and brought to the attention of the professional but that is ignored or left unaddressed. Thus, it is clear that harm can be caused both by actions and by inaction. APNs can do harm in several ways; most are unintentional but nevertheless often avoidable:

- APNs might fail to adequately understand a patient's needs and thus not protect him or her from preventable harms related to unmet needs.
- An APN's skills and competence might be inadequate to care for the patient's recognized needs, yet the APN fails to seek qualified assistance.
- The APN can neglect to anticipate foreseeable harmful effects from a proposed course of action.
- The APN can fail to intervene to protect a patient against the actions of an impaired, incompetent, or careless colleague.
- The APN can fail to assist the patient manage pressures from others that result in the patient accepting unwanted treatment.

In advanced practice roles, nurses can also cause harm by referring patients to inappropriate colleagues or not adequately training or supervising others who are caring for the patient under the APN's direction. Patients can also be harmed by ongoing interventions that are not likely to achieve desired effects (for example, chemotherapy that can only minimally prolong life and causes suffering in the process). Nonmaleficence, then, is closely aligned with ideas of accountability for the APN's own practice and for practice actions. *Accountability* means that care providers take responsibility for trying to anticipate foreseeable harms so that these can either be minimized or are balanced against the good that the actions are intended to achieve. Moreover, the effects on the nurse of causing or not preventing harms include moral distress, as noted earlier. Because moral distress can lead to a nurse distancing himself or herself from patients or even to leaving the profession, more diffuse harms to patients may result from the loss to the profession of experienced, caring nurses. The APN can inadvertently cause harm through ignorance, incompetence, or failure

to understand the patient's unique needs and desires. Harm can also be caused to patients when the APN cannot get them optimal treatment.

Additionally, nurses can cause harm indirectly. The principle of nonmaleficence provides what in legal terms would be called a duty of due care. "Due care is taking sufficient and appropriate care to avoid causing harm, as the circumstances demand of a reasonable and prudent person" (Beauchamp & Childress, 2009, p. 153). Another implication of this principle is that APNs are responsible for balancing the risks of interventions and treatments with the likely benefit. As illustrated with the chemotherapy example, within acute care settings harm can be caused by continuing life-sustaining treatments when the chances of recovery are minimal.

The Principle of Beneficence

For healthcare professionals, the principle of beneficence might be viewed as a more active principle than nonmaleficence because it is the duty to provide a good or to benefit persons. In a sense, the very reason for the existence of the healthcare professions is beneficence. These professions exist to provide a service that requires specialized training and skills. In public life, *beneficence* "connotes acts of mercy, kindness, and charity" toward others (Beauchamp & Childress, 2009, p. 166). It concerns the duty one person has to provide benefit to another. Certain moral theories, such as utilitarianism, have as their singular underlying premise the idea that people have a duty to maximize the good in society. Beneficence is unlike nonmaleficence in that it is not morally required of societal members except in special circumstances such as parents or guardians toward their wards. "Whether beneficence is viewed as a moral requirement of societal members very much depends upon [the] philosophical beliefs," culture, and values of the individual or prevalent societal values (Grace, 2004a, p. 317). Although beneficent actions may not be morally required, they do serve a purpose in maintaining the cohesiveness of society. In Western countries at least, and to greater or lesser extent in other countries, people tend to think that if they can easily help someone who is struggling, then they should. This is the basis for charitable actions.

In healthcare settings, though, beneficence is viewed as the duty to maximize benefits and minimize harm to patients. It is morally required of the clinician acting as clinician, whether they are physicians, nurses, physical therapists, respiratory therapists, and so on. The goals of healthcare professionals are beneficent: they are inherently for the patient's good, and more broadly, to further societal health. As argued earlier, healthcare professions exist because they provide a critical good for persons. Therefore, beneficence underlies all actions of the professional while engaging in role-related activities.

Paternalism. Paternalism is often taken to be a derogatory attitude that connotes one person's attempts to control another or condescension toward another. However, in its original or legal sense, the concept of paternalism is both an ethical and a legal principle that protects the interests of one who cannot be self-protective. The principle is derived from the term parens patriae, or the state's interests in protecting the vulnerable in society from neglect or abuse. There are extensive philosophical and political debates about whether and when legislative or governmental paternalism is permissible (for the collected arguments, see Coons & Weber [2013]). However, in healthcare settings paternalistic actions are ethically permissible or even obligatory—depending on the

circumstances—if they serve an incapacitated person's best interests. A person is incapacitated when he or she is unable to make a substantially informed decision as described under the principle of autonomy.

Paternalistic actions, then, are beneficent actions. They promote the good for a person who is unable, whether because of cognitive or developmental status, to advocate for his or her own best interests. These best interests can be served by using the person's own history, values, and beliefs where possible. However, in the case of a person who has never had capacity or whose history is unknown or unknowable, the standard used is that of a "reasonable person," as discussed earlier. Beauchamp and Childress (2009) define *paternalism* as "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden" (p. 208). Thus, the patient's own interests are the main focus of paternalistic actions. In viewing paternalism this way, it becomes clear that knowledge of the patient in context and as an individual with a life history, beliefs, and values, where this is possible, is a crucial goal of paternalism. Beauchamp and Childress (2009) propose five criteria for justifying paternalistic actions:

1. A patient is at risk of a significant preventable harm.
2. The paternalistic action will probably prevent the harm.
3. The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
4. There is no reasonable alternative to the limitation of autonomy.
5. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted. (p. 216)

To summarize, paternalism is sometimes understood differently in healthcare settings than warranted by a fuller understanding of the principle. It has assumed negative connotations in many instances. Some people, nurses and others, have used it to label the condescending, arrogant, or even self-interested behavior of healthcare providers toward patients who they think are making bad decisions. Patients may be persuaded to accept certain treatments, important information may be withheld from them, or a competent patient may have his or her decision overridden. Understanding the real nature of paternalistic actions as both beneficent (patient's best interests) and supportive in the long run of autonomy (restoring the patient to a state where autonomy can be exercised) keeps the focus on the needs of the patient and away from the lure of expediency or other conflicts of interest.

Conflicts Between Beneficence and Autonomy

Sometimes ensuring beneficence seems to be in conflict with the principle of autonomy. For example, a patient with impending sepsis refuses to have a cannula inserted so that treatment with fluids and antibiotics can begin. At first sight, it seems as if there is a dilemma: honor her autonomy or override it and give the fluids because this is what will save her life. The conflict, however, may be false. If the patient does not meet all of the criteria for voluntary informed consent, then she is not capable of exercising her autonomy. She is not adequately aware of the risks and benefits of refusal. Thus, the beneficent action is to treat but to minimize the harms that may stem from overriding her decision. She may, for instance, feel disrespected or that her trust was undermined. Additionally, beneficence supports the idea that as soon

as the patient regains decision-making capacity, she resumes her right to make her own decisions, as long as these are adequately informed and align with her own life values and goals. Beneficence does not, as some have assumed, mean that providers know what is best for the patient, but rather that decisions are made based on the individual patient and his or her values, beliefs, and what is known about the patient's life and preferences. In overriding a person's autonomy, health professionals are still charged with formulating actions that accord with an understanding of the patient as an individual with unique characteristics.

The Principle of Justice

Several different conceptions of justice exist. In Western societies, *retributive justice* has to do with punishment for problematic actions; *restorative* or *compensatory justice* has to do with restoring to people what they lost in being harmed by another or others. These two forms can be considered noncomparative stances or perspectives. They both are concerned with "seeing to it that people receive that to which they are entitled, that their rights are recognized and protected" (Munson, 2008, p. 774). *Comparative justice,* in contrast, has to do with how the benefits and burdens of living in a social context—where people are dependent on one another for certain goods and services—should be distributed across a society. For health care and healthcare delivery purposes, distributive justice may also be called *social justice*. It is an important ethical principle in times or circumstances of limited resources or gross disparities among the living conditions of different groups.

Philosophical theories of justice try to show what are or would be sound justifications for the rules of distribution. In this sense, then, comparative justice is social justice. Theories try to delineate which formal social systems will result in the fairest conception of deciding who should get what in terms of social goods such as education, food, shelter, and health care. Buchanan (2000) reports that social justice has been an important concept for centuries and continues to be "central to human understandings of socially significant values" (p. 155).

There are two broad socially oriented ideas regarding justice. One perspective views justice as being based on deserving it: those who are more worthy of merit or who contribute more are viewed as deserving of better social benefits. The other perspective views justice as equalizing benefits across society regardless of merit. This latter view is "justice as fairness" (Grace, 2005, p. 120).

In the literature related to health care, the predominant accounts are of justice as fairness. The principle of equality underlies accounts of justice as fairness. Justice is impartial in the sense that each person is considered initially as equally worthy of concern. Underlying the various theories is a basic principle that "similar cases ought to be treated in similar ways" (Munson, 2008, p. 774). The conception of distributive justice that is probably most often cited contemporarily is that of John Rawls. His work, *A Theory of Justice* (1971), is a systematic look at the sort of social structures that would have to exist for justice as fairness to prevail. Rawls takes as a starting point Kant's ideas about people as rational and able to divine which actions are morally permissible, obligatory, or forbidden. Rawls's method is a hypothetical device. That is, he wants to show what the underpinnings of a just social system would be and what just institutions would look like. Because man is his own lawmaker, as we have seen from the idea of the Categorical Imperative (the right action is the one that I could agree everyone else *should* take in similar circumstances; that is, it is ethically sound),

the design of the system will be dependent on a "group of persons" in the "original position" (Rawls, 1971, p. 12) who do not know their standing in society, or what physical characteristics or material goods they would possess, nor what their "natural assets . . . and abilities" (p. 12) would be. The hypothesis is that such a group would come up with the rules and standards necessary for the initiation and arrangement of institutions that would ensure everybody is served fairly. That is, if one did not know whether one would be rich or poor, one would be more likely to build in remedies for those who are the least well off even if that did somewhat disadvantage those who are well endowed with worldly goods.

Rawls identifies two rules of justice that he believes would emerge from a group's deliberations taking place behind this "veil of ignorance" about their individual states and traits (Rawls, 1971, p. 136). "First: each person is to have an equal right to the most extensive liberty compatible with a similar liberty for others. Second: social and economic inequalities are to be arranged such that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all" (Rawls, 1971, p. 60).

As might be expected, Rawls's theory is subject to a variety of criticisms, including that the nature of human beings is such that this would not eliminate jockeying for power and advantage and would thus upset any ethical system initiated. However, the salient aspects of the theory for the purposes of this discussion are that justice in this sense means being alert to inequities and being willing to address them. Any inequities within a society's arrangements should be slanted toward benefiting the least well off. In contemporary U.S. health care, most would agree that justice as fairness might be accepted in spirit but not in reality. Nevertheless, for APNs the ideas behind justice as fairness cohere with the premises of the ANA's (2010) *Social Policy Statement* and its *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015). Therefore, it is among APNs' professional responsibilities to promote justice in health care, because without this, the most vulnerable will remain most at risk for not receiving good care. A recent compendium of articles (Kagan, Smith, & Chinn, 2014) provides the most comprehensive discussion to date of nurses and nursing's role in working toward socially just health care. In Chapter 4, the dual issues of human rights and social justice are discussed and exemplified in more detail.

Justice is an important concept for nursing related to influencing policy, conducting research, educating nurses, managing care, and reducing health disparities. The important thing to keep in mind about justice as fairness is that it is an impartial look at inequities. It might be a requirement of justice as fairness that the special needs of a disadvantaged group be considered, but each member of the group is impartially and equally accorded that consideration. Note that this is *not* the same thing as saying everyone is or should be equal in terms of capacities and possessions. The nature of justice in health care, then, is that in some circumstances it might give rise to tensions for the APN. For example, a nurse's clinical judgment leads her to believe that her patient needs an expensive drug that is not on formulary, perhaps because of prior sensitivities to other drugs or because current drugs are detrimental in some other way. She feels that she must advocate for her patient to get this drug and that other patients might also benefit but not to the same degree. In advocating for this treatment, resources may be diverted away from others in her care, and this must be part of the decision-making considerations.

Others have argued that although justice as fairness is meant to ensure equal consideration for like cases, in practice people who are perceived as the most meritorious

sometimes receive priority over those with a higher need. For example, celebrities seem to get moved up the waiting list for organs more rapidly than others who may be in more immediate need or have fewer resources, or they may get moved through the system faster (Alfandre et al., 2016; Simmerling, 2007).

The justice as fairness perspective in healthcare settings also tends to be directed toward the allocation of scarce resources in terms of technologically or biologically based innovations and interventions and as arising within the healthcare institution or as a result of the types of insurance or funding available. The disease model of health care predominates in the United States in a way that it does not (or not so much) in other countries with universal healthcare coverage. This sometimes directs attention away from looking for inequalities as arising from the "fabric of society" (Grace & Willis, 2012). Therefore, more than just redistribution of resources is necessary to rectify injustices and to promote health and healing. In an article in *Nursing Outlook,* my colleague Danny Willis and I (2012) critiqued the problem that social justice viewed as fairness does not necessarily facilitate looking for the source of intractable injustices in the fabric of societal institutions and arrangements. Moreover, injustices can seriously affect health or the ability of persons to heal. We used an alternate conception of social justice to look at the problem of child abuse and its long-range effects on health. Powers and Faden's (2006) model takes the job of social justice as being concerned with ensuring a basic minimum level of six essential dimensions of well-being needed for living a "minimally decent" life (Grace & Willis, 2012). This conception matches the responsibility of the nursing profession for individual and societal health as outlined in the nursing code of ethics for various countries, including the ANA (2015) and the International Council of Nurses (ICN, 2012). Chapter 4 on human rights and responsibilities expands on the discussion of justice presented here. For the purposes of this text, it is necessary to have a foundational understanding of justice in order to optimize health, for both individuals and the larger society.

The Principles of Veracity and Fidelity

These two principles, while not achieving the same status in healthcare ethical decision making as Beauchamp and Childress's framework of the four ethical ideals discussed earlier, are nevertheless important in professional ethics. They represent professional characteristics or intents that support the realization of autonomy, beneficence, nonmaleficence, and even justice. Veracity is about the duty to be truthful. The term has its origins in the French *véracité* and medieval Latin *veritas* and means "the quality or character of speaking the truth . . . truthfulness, honesty, trustworthiness" (Brown, 1993). A related principle is that of fidelity. *Fidelity* means "loyalty, faithfulness, unswerving allegiance" to another (Brown, 1993).

Veracity. Although it might seem that veracity is a simple concept—of course APNs should be truthful in their dealings with patients, families, and others—this is not always so easy to accomplish, especially in light of trying to honor the principles of beneficence and nonmaleficence. What does it mean to be truthful? Truthfulness is generally thought to be supportive of autonomy, but is it always? Beauchamp and Childress (2009) note, "[v]eracity in the health care setting refers to comprehensive, accurate, and objective transmission of information, as well as to the way the professional fosters the patient's or subject's understanding" (p. 289). But stark veracity can be harmful to some patients in certain circumstances. Additionally, APNs do

not always know what interventions work under what circumstances. How, then, can APNs decide when, if ever, the standard of veracity should be bent for the good of the patient? Sissela Bok (1999), in her seminal work *Lying: Moral Choice in Public and Private Lives*, pointed out "the lack of a theory of moral choice which can help in quandaries of truth-telling and lying" (p. xxxi). How do APNs determine what and how much information accomplishes professional goals of providing for patient good? Bok (1989) delineates three arguments that are generally given to support less than full disclosure to patients: "truthfulness is impossible; that patients do not want bad news; and that that truthful information [can cause] harms [to patients]" (p. 129). Each of these stances is susceptible to argument. During the course of the book, the issue of using ethically supportive clinical judgment in decision making is illustrated via cases. The extent and intent of veracity, nuances of veracity, and the permissibility, nature, and role of deception are also explored in more detail in later chapters. In giving honest information, the delivery and extent of information are necessarily tailored to the knowledge of the patient, who he or she is, and what he or she wants to know, as far as this is possible. All of the following can be used in determining how to use truthfulness to benefit the patient and uphold his or her autonomy: clinical judgment, collaboration, evidence, knowledge of the patient (including cultural needs), and a clinical decision-making framework. Self-reflection related to biases and prejudices as well as reflection on practice are important elements of decision making related to the continuum of veracity. In general, veracity supports trust in the professional, other professionals, and the institution.

Fidelity. The duty of allegiance to the patient is closely aligned with the idea that healthcare professional relationships are fiduciary or trust relationships, as discussed earlier. Provision 2 of the ANA's *Code of Ethics for Nurses with Interpretive Statements* (2015) states: "The nurse's primary commitment is to the patient, whether and individual, family, group, community, or population." Element 1 of the ICN's (2012) *Code of Ethics for Nurses* asserts, "[T]he nurse's primary professional responsibility is to people requiring nursing care." There are many opportunities for nurses and other healthcare professionals to be sidetracked from this priority. Nurses working within institutions and practices may experience pressures to follow the wishes of their employers, supervising physicians, or administrators. Many other conflicts of interest exist within healthcare settings and must be negotiated. Additionally, for providers who work within the prison system or the armed forces, there may be overt priorities that work in opposition to a focus on the good of the patients (Williams, 2009).

Other Approaches

Several other helpful approaches can assist in ethical decision making. These are discussed briefly in the following sections. They are not theories; rather, they are added dimensions that permit looking more deeply into the underlying conditions that give rise to practice problems. They help clarify the dimensions of an issue or dilemma.

Feminist Ethics and the Ethics of Care

Over the past few decades, feminist philosophers have criticized analytic philosophical theory and its methods as they are applied in healthcare settings (Donchin & Purdy,

1999; Tong, 1997; Warren, 2001). They suggest that in addition to moral theory and reasoning, ethical decision making in health care requires the "unearthing of buried assumptions about the influence of power in relationships and situations" (Grace, 2004a, p. 302). *Feminist ethics*, then, is not a singular approach but an assortment of perspectives. "A feminist approach is defined by taking as its starting point the experience of women, by acknowledging that this experience is characterized by oppression and domination" (Peter & Liaschenko, 2003, p. 33). Feminist ethics approaches do not limit themselves only to the concerns of women, but address oppression and domination wherever they occur. Other issues of concern are "race, class, disability, sexual orientation, and so forth" (Peter & Liaschenko, 2003, p. 37).

This is different from the focus of many of the theories explored thus far. The traditional moral theories tend to view persons as isolated individuals with the right to have their autonomous actions protected or to pursue happiness. Davis, Aroskar, Liaschenko, and Drought (1997) note that Gilligan's research on moral development revealed women's moral concerns to be focused more on "care and responsibility in relationships rather than on the application of abstract principles such as respect for individual autonomy and justice" (p. 58). This is an important insight for nurses because their work is most frequently with individuals and the goals of the profession include caring for the individual as a unique being in all of his or her complexity. Good nursing care involves engagement with the patient and a willingness to focus on the whole person in context. This means that nurses understand the place and importance of significant others in the patient's life.

Feminist perspectives are also helpful in looking at the contexts within which nurses work. Feminist ethics supports the idea that "moral decision-making must include an investigation of both hidden and overt power relationships implicit in ethical problems" (Grace, 2005, p. 105). Questions to pose from a feminist perspective, when involved in ethically challenging situations, include: What are the power structures—social, institutional, or interpersonal? Is there an imbalance? Who has an interest in keeping a power imbalance? How is this affecting the patient or the decision making? How can we change the focus of power or empower the person who is the primary focus of the issue?

Narrative Ethics

Narrative ethics represents another contemporary approach to addressing ethical issues. Narratives are stories of people's lives or situations told with rich detail and often from different perspectives. They are most frequently used either in a teaching/learning environment or as an after-the-fact exploration of a difficult case. In narrative ethics, stories are used to explore hidden facets of morally worrisome cases. They may portray the experiences of different persons involved in the story, giving fuller dimensions than usually available in a clinical case presentation. Narrative explorations permit the fleshing out of nuances in a given situation as well as stimulating further questions to be asked. Stories also permit people to vicariously engage in the experience of another from their own subjective stance. This can enhance empathy and compassion, which in turn facilitate understanding of how the person or situation got to a certain point in time. Stories are attentive to context and evolve over the time period of the narrative rather than being a static time slice. Narrative ethics is also a way of learning from situations that have already occurred. Criticisms of narrative

ethics include the problem that it is difficult to apply ethical norms or determine what the good action would be.

Summary

This chapter systematically introduced the idea that professional nursing practice is intimately related to philosophy, moral philosophy, and applied ethics. Theories and principles of ethics were discussed in light of their uses, scope, and limits for good decision making in healthcare settings. These ideas will be elaborated on, put into context, and become more familiar as they are used to explore or analyze cases in this text. The following discussion questions are designed to help you understand your own professional values. There are no right or wrong answers, only thoughtful and interesting ones.

Discussion Questions

1. Preventive ethics is the anticipation of potential problems, followed by actions taken to stop the further development of those problems. For critically or chronically ill patients, inadequate consideration of end-of-life options can give rise to patients receiving care and treatments they do not want or not receiving the care and treatments that they do want.

   Mrs. Durant is a 75-year-old patient who has experienced a return of breast cancer that was successfully treated 20 years earlier. She now has bone metastases. She is eligible for a chemotherapy protocol that may extend her life for up to a year, but it is not expected to be curative. As an oncology nurse specialist, you are charged with discussing options with Mrs. Durant.

   In what ways do the principles and concepts explored in this chapter permit gaining clarity about the situation and thus facilitate preventive ethics? The goal of preventive ethics is to facilitate good patient care and prevent the development of dilemmas or ethical crises.

2. Virtue ethics is another approach. In virtue ethics, the idea is that a person can cultivate a good character. The argument is that "a person of good character will engage in good actions." Thus, the actions of a good nurse would necessarily be good.

   Do you think a good character can be cultivated?
   Does the nurses' code of ethics from your country or the ICN code support this idea?
   What is a good person?
   What is a good nurse?
   Would a good nurse necessarily be a good person?
   What characteristics would a good nurse possess?

   Present counterexamples (examples that would point to flaws in virtue ethics theory) and discuss these with your peers.

3. How has this chapter changed your understanding of nursing or healthcare ethics?
4. Knowledge of theories and principles is necessary for dialogue and collaboration with other professionals in the interest of good care for the patient. Do you agree with this statement or not? Defend your answer.

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