

# Principles of Ethics

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### Introduction

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What kinds of acts are right in oncology nursing practice? This basic yet complex question is commonly asked by nurses in oncology and other specialties to determine what they should do in a specific case or how the entire profession should act regarding interactions with patients, families, and colleagues. General ethical principles often are used as guides for right action. The first such contemporary example that proposed principles as guides in a health-related area was the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979), which identified the principles of respect for persons, beneficence, and justice in human subjects research. In 1981, Beauchamp and Childress built on this work and applied it to health care in the first edition of their book *Principles of Biomedical Ethics*, now in its seventh edition (Beauchamp & Childress, 2012). They proposed four key principles: respect for autonomy, beneficence (the obligation to do good), nonmaleficence (the duty not to harm), and justice. Others in bioethics have suggested additional derivative principles, including veracity (the obligation to tell the truth), fidelity (the duty to keep promises), and avoidance of killing (Veatch, Haddad, & English, 2010).

Although helpful in illuminating shared values and important ethical norms in health care, the principlist approach to ethics is not without its problems and critics. For example, polarities and problems exist within the principles themselves, such as tensions between present versus future expressions of autonomy (Collopy, 1988) or disagreement regarding who is best suited to determine benefit (Childress, 1982). Conflicts can also arise between principles, such as when one is attempting to fulfill the demands of respect for autonomy, which can run counter to the health professional's obligation to avoid harm. Additionally, no one principle of the four is given primacy, so determining which principle carries the day in

a specific case is difficult. Critics have noted that the universal, objective nature of principlism seems to ignore the specific context of an ethical action, which they consider to be an integral component of moral decision making and reflection (Clouser & Gert, 1990; Jecker & Reich, 1995). Even with these criticisms and problems, principlism is the most commonly used approach in healthcare settings and, therefore, is an important part of ethical deliberations.

The focus of this chapter is to provide an introduction to the contributions of ethical principles to oncology nursing practice as well as their limitations. Emphasis is placed on the word *introduction*, as the discipline of ethics is complicated and what may at first appear to be a clear application to practice often has hidden difficulties. A helpful metaphor for the discussion of principles and other components of ethics is to think about what happens when a flashlight shines in a darkened room. A flashlight highlights wherever its beam falls and obscures everything else in the room. The flashlight also causes us to see things in a different, heightened way than we would under normal lighting (Dougherty, Edwards, & Haddad, 1990).

Principles and other elements of ethics often work in a similar way. Principles can illuminate realities and relationships that we might not have noticed otherwise, but they can also de-emphasize other equally important components of ethics. To help provide a more complete picture of what is involved in ethics, the selected case study aims to not only highlight where traditional ethical principles are at play in oncology nursing practice but also to enhance understanding of ways to approach ethical concerns.

## Basic Principles of Ethics

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Ethics is the branch of philosophy that explores moral duty, values, and character. In effect, ethics involves the study of right and wrong, moral responsibilities of actors, individual/institutional/societal moral conduct, promises, rules, principles, and theories. The study of ethics can also involve the moral value of relationships and other contextual issues, such as power structures and sources of knowledge. Together, these constitute important concerns in contemporary ethics. As noted, there are several approaches to ethics, but the one that is most relevant to an exploration of ethical principles is normative ethics. “Normative ethics raises the question of what is right or what ought to be done in a situation that calls for a moral decision. It examines individual rights and obligations as well as the common good” (Davis, Aroskar, Liaschenko, & Drought, 1997, p. 2).

This chapter will examine the relationship of principles to ethical situations in oncology nursing. However, the moral life is more than merely making discrete decisions to do this or not do that but rather encompasses how people live and think about these matters and, perhaps more importantly, how people work with others to discern the course of action. Therefore, reflection and discussion about

ethical actions is also necessary for a fuller understanding of what acts are right. How nurses live the practice of and think about oncology nursing is particularly important because of the often life-threatening and always life-altering nature of cancer. Even in cases where cancer becomes a chronic condition with years of remission and recurrence, the nature of a cancer diagnosis often places the oncology nurse in complex ethical situations.

A brief, overarching explanation of the principlism of Beauchamp and Childress (2012) in their now classic *Principles of Biomedical Ethics* is in order before turning to specific principles. Beauchamp and Childress (2012) proposed a methodology to resolve ethical problems that is universally applicable in healthcare settings. As described by Viafora (1999), “Principlism relies upon a core of fundamental principles—themselves based upon some general theory—to be applied to rules which function as action-guides” (p. 285).

Therefore, the principles serve as a framework, and health professionals provide the “facts” of the situation or case in question, which when fed into the framework should ideally provide answers or, at minimum, insight into morally correct options.

Principles are based on more general theories. It is helpful to distinguish which theories support which principles. By shining a light on the theory, one can see the differences between principles that are oriented to consequences of actions and those that assert that the rightness or wrongness of an act is inherent in the act itself. The theoretical approach to ethics that focuses on outcomes is often referred to as the *consequentialist view*. A consequentialist deems actions as morally correct when they promote good. In other words, one should choose the action that brings about the most good, or, if there is little chance for a good outcome, the action that yields the least harm. An example of consequentialism in health care is the Hippocratic tradition in medicine that is based on the promotion of good for patients to the exclusion of other goods (Edelstein, 1987). Emphasis on the primacy of patient benefit is also evident in the American Nurses Association’s (ANA’s) *Code of Ethics for Nurses*, which states, “The nurse’s primary commitment is to the recipients of nursing and healthcare services—patient or client—whether individuals, families, groups, communities, or populations” (ANA, 2015, p. 5). There are, of course, more complicated theoretical models of consequentialism, but this basic definition will suffice for this introductory chapter. Principles that derive from a consequentialist perspective are beneficence and nonmaleficence, two of the foundational principles proposed by Beauchamp and Childress (2012). Even without a background in philosophy, almost all health professionals would acknowledge the duty or obligation to do good for patients and to avoid as much harm as possible. Although the two principles can, and some would argue should, be discussed separately, they often are intertwined in clinical practice. One distinction between the two principles is that nonmaleficence is an absolute moral duty in that one is always obligated to avoid harming others. The principle of beneficence, however, is almost an imperative in health care in that it implies that one should promote good but not to the same degree

in every case. Beneficence, therefore, is a relative duty in that the obligation to do good for others is tempered by other factors, such as the relationship held by those involved.

### **Nonmaleficence**

The obligation not to harm others would seem to take priority over most other ethical principles. Beauchamp and Childress (2012) noted the connection between the principle of nonmaleficence and beneficence but resisted the idea of a hierarchal ordering of the two principles. They proposed the following norms:

Nonmaleficence

1. One ought not to inflict evil or harm.

Beneficence

1. One ought to prevent evil or harm.
2. One ought to remove evil or harm.
3. One ought to do or promote good.

Each of the three principles of beneficence requires taking action by helping—preventing harm, removing harm, and promoting good—whereas nonmaleficence requires only intentionally refraining from actions that cause harm. Rules of nonmaleficence therefore take the form “Do not do X.” (Beauchamp & Childress, 2012, p. 152)

Some rules, such as “Do not lie to a patient” or “Do not harm one patient to benefit another,” conform to the aims of nonmaleficence. However, as with most clinical situations, the rule of not harming is not as clear when applied to clinical practice. For example, a patient with metastatic cancer develops a bowel obstruction that appears to be due to benign strictures from previous surgery. Surgical intervention is indicated to correct the bowel obstruction, but, given the patient’s cancer stage and general physical condition, the treatment team is divided regarding whether surgery in this case is a benefit or a harm. As with any surgical procedure, there are inherent risks and, given the patient’s health status, the long-term benefits from surgery seem small in comparison. The short-term benefits of surgery, though, may loom large for the patient because of the nausea and acute pain that accompany bowel obstruction. There are also immediate life-threatening implications, such as ischemia of the bowel, that could be weighed differently by the patient and the surgical team. Thus, defining harm in order to avoid it is a more nuanced task than it first appears. Clinical parameters, patient and health professional values, and the relative balance between harms and benefits all play a part in determining harm.

### **Beneficence**

The duty to do good is a strong one in health care. Whether informed by a religious tradition or basic human concern for the well-being of others, the

directive to “love thy neighbor” underlies the actions of health professionals. Although we may be called to “love one another” in the broadest sense, it is clear that our capacity to love is limited by many things, including lack of time, knowledge, or resources. So, beneficence, the duty to do good, is limited, and we must choose among limited options to determine where we can do the most good (Glaser, 1994).

In the delivery of oncology nursing care, all of the nurse’s actions are directed toward the good of the patient in whatever way “good” is defined. Beneficence is demonstrated in the smallest of actions and interactions with the patient, from a comforting touch to attentive listening. In addition, the principle of beneficence requires respect for the wishes and choices of the patient or family because such choices reflect interpretation of the good or what is of benefit. The nurse also has a privileged perspective on decisions and outcomes because of advanced education and experience. In contrast, the patient may be at a disadvantage when making decisions because of lack of healthcare knowledge and the additional stressors of illness. This is where other ethical principles come into play, such as respect for autonomy and the derived principle of consent that bolsters the patient’s ability to make informed decisions. Beyond ensuring that patients have adequate information to determine the good and bad outcomes of actions, there can be differences in how the good is interpreted. For example, pain management would seem to be an uncontested good in patient care. However, the experience of pain and pain tolerance is highly subjective. Some patients may insist on the complete elimination of pain, whereas others may tolerate more pain to maintain a greater degree of consciousness. Patients may attach religious or redemptive meaning to pain that will alter how they consider the benefits and harms of pain relief. What may seem like a straightforward “good” in oncology nursing (i.e., relieving pain) is complicated in clinical practice. Discerning benefit should be an ongoing, collaborative process between the patient and family and the nurse. Balancing goods and harms as a broader principle is sometimes referred to as *proportionality* and will be discussed later in this chapter.

### **Respect for Autonomy**

Some principles are based on the inherent rightness or wrongness of an action rather than the consequences of the action. “These positions, collectively known as formalism or deontologism, hold that right- and wrong-making characteristics may be independent of consequences, that morality is a matter of duty rather than merely evaluating consequences” (Veatch et al., 2010, p. 11). The duty to respect autonomy is one of these principles. The concept of respect for autonomy is based on a more fundamental principle of respect for persons. Respect for persons requires that individuals treat each other with respect regardless of conditions such as status, age, race, decision-making capacity, and so on. People are obligated to respect others merely because they are human. People are not, however, obligated to respect any and all actions of others, which is an important distinction.

If people are duty-bound to respect others, it follows that people should also respect their ability to make choices about how they will live their lives. The most fundamental aspect of respect for autonomy is the notion of noninterference with others. In a world of strangers, this idea of leaving others free to carry out their daily lives and business makes sense. Noninterference in healthcare relationships, however, does not make as much sense because health professionals are essentially asked to “interfere” with deeply personal facets of a person’s life in order to cure, heal, and comfort.

Where autonomy plays a larger role in healthcare interactions is respect for self-determination, or being one’s own person and making decisions about one’s own well-being. Autonomy reflects a person’s ability to express needs and control decisions. Whenever a person is ill, autonomy can be threatened. Patients with cancer need to make decisions about many aspects of their care, including whether to pursue standard or experimental treatment, which requires a higher level of informed consent. Because no one is capable of being completely or fully autonomous, acceptance occurs along a range of substantially autonomous decision making in which a person has “enough” understanding, information, and freedom to come to a sound decision in a particular context (Beauchamp & Childress, 2012). The amount of understanding, information, and freedom will vary from person to person and within the same person over time because of illness or injury. Determining whether a decision or action is substantially autonomous is important because of the obligation to honor autonomous actions even if the decision could lead to harm.

## **Justice**

The principle of justice addresses the proper distribution of benefits and burdens. The allocation of healthcare resources is an abiding problem in health care. Oncology nursing is no exception. Distribution of resources can occur on various levels, from societal to personal. Justice also embodies the ideal of fairness. When one thinks of what is fair or just in a situation, he or she usually thinks about claims between people and rules to help mediate such claims. Consider the following example: Three patients arrive at the same time for their chemotherapy treatment at an ambulatory oncology clinic. One patient has arrived early for her appointment because she wants to talk to the nurse about a list of side effects and possible homeopathic remedies. The second patient is very weak and seems somewhat short of breath. The third patient is here for his final round of treatment and currently has few complaints. The nurse notes that all the other clinic nurses are busy, so she cannot delegate to a peer. She must decide which patient will get her initial attention. In order to make such a decision, the nurse is relying on principles of justice. The nurse could decide to spend her time with the patient where her actions will do the most good. Or, she could decide to direct her attention to the patient in the greatest need. Determining the distribution of healthcare resources, whether they be nurs-

ing time, access to diagnostic tests, or expensive medication, is one of the most complicated ethical problems in health care today.

Three additional principles deserve mention because of their importance in clinical practice: truth telling, fidelity (promise keeping), and avoidance of killing. These three principles are duty-based in that the right-making characteristic of the principles are inherent in the principles themselves, not the consequences.

## Truth Telling

The principle of veracity, or truth telling, requires that healthcare providers be honest in their interactions with patients. “Traditional ethics holds that it is simply wrong morally to lie to people, even if it is expedient to do so, even if a better outcome will come from the lie. According to this view, lying to people is morally wrong in that it shows lack of respect for them” (Veatch & Haddad, 2008, p. 102). Being honest with patients helps to build and maintain trusting relationships that are essential to the delivery of quality patient care. However, as with the other principles, telling the truth to a patient is not always viewed as the right thing to do. Although mainstream American culture holds honesty in high regard, other cultures do not. In fact, telling sick and dying people about their conditions, particularly in the case of terminal illness, can be seen as cruel and even harmful by certain ethnic and racial groups (Blackhall, Frank, Murphy, & Michel, 2001). The principle of truth telling is influenced, interpreted, and valued differently because of the backgrounds, education, and socioeconomic status of providers and patients.

## Fidelity

Moral theologian Paul Ramsey maintained that the fundamental question in healthcare ethics relates to the principle of fidelity.

We are born within covenants of life with life. By nature, choice, or need we live with our fellowmen in roles or relations. Therefore we must ask, what is the meaning of the *faithfulness* of one human being to another in every one of these relations? This is the ethical question. (Ramsey, 2002, p. xlv)

Fidelity is rooted in respect for persons and truth telling. Faithfulness to promises is important in relationships because it indicates the level of esteem held for one another and establishes trust. When a person makes a promise, he or she creates expectations of another. The person expects to rely on the promise and have a valid claim that it will be kept. When a nurse assures a patient that he or she will receive appropriate symptom management while undergoing chemotherapy, the message does not have meaning unless the nurse follows through on that promise when it is actually needed during treatment. Fidelity is also important in interactions with peers on the healthcare team. Generally, promises to peers are not explicit but are shown through actions that implicit promises are being

kept regarding important aspects of working together, such as honesty, not taking advantage of each other, and demonstrating dependability to be there for help and assistance when needed.

### **Avoidance of Killing**

Although the principle of nonmaleficence would seem to prohibit active killing, some ethicists have argued that the seriousness and finality of killing requires a separate principle that specifically recognizes the prohibition (Veatch, 1981). Active killing can be deemed wrong from consequentialist (great and irreversible harm occurs) and duty-based (violates autonomy) perspectives. However, there are instances when killing could be justified, such as during war or in self-defense. There are also instances in which a person could consent to killing, as is the case with assisted suicide or voluntary euthanasia. Even with consent and the backing of law, as is the case in the states of Montana, Washington, Oregon, Vermont, and California, traditional religious and secular ethics has held to a prohibition of killing, even for merciful reasons. Patient requests to hasten death occurred frequently enough in oncology nursing practice that the Oncology Nursing Society (ONS) developed a position statement on hastening death. In the position statement, ONS recognized the nurse's right "to refuse to be involved in the care of patients who choose hastened death as a course of action" in jurisdictions where it is legally sanctioned (ONS, 2010, p. 249). The position statement also indicates that as a professional organization, ONS does not support actions that hasten death. ANA (2013) held a similar view in its position statement on euthanasia, assisted suicide, and aid in dying. In 2011, the Hospice and Palliative Nurses Association (HPNA) issued a position, endorsed by ONS, that identified nurses' rights to "decide whether their own moral and ethical value system does or does not allow them to be involved in providing care to a patient who has made the choice to end his or her life through [assisted death]" (HPNA, 2011, p. 2).

### **Virtue and Care-Based Ethics**

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While principlism focuses on actions, the character of the actor and where the actor is situated are obscured. Once again, a brief overview of two other approaches to ethics, virtue and care-based, provides a fuller view of ethics. Virtue ethics spotlights moral character rather than actions, as the following summary description of the theory notes.

Virtue ethics starts instead with the insight that our actions, by and large, are not isolated decisions that we make, but arise from our character, the deeper complement of typical patterns of behavior that we exhibit, and the values that we hold. These character traits are not static, but are shaped and re-shaped con-

tinually by the actions we choose, and our reflection on those actions and their meaning in our lives. (Fullam, 2006, para. 2)

The development of virtues is, therefore, a formative process that is shaped by many elements. Role models likely contributed to the person that each individual has become. Beyond personal virtues, one can also consider the virtues of the whole nursing profession. Consider which virtues are central to oncology nursing, such as compassion, competence, and courage, and how these virtues are supported and nurtured in clinical practice. Such virtues incline the nurse who possesses them to act in certain ways regardless of whether there is supporting knowledge about which ethical principle justifies the actions.

Care-based ethics is often associated with responsiveness to particular incidents rather than an objective moral view. The details matter in care-based ethics, as do relationships. Care-based ethics also recognizes a sort of kinship with others who share the human condition and all of its frailties. Such a view acknowledges that people are not all equally situated in life and that these differences in status and other aspects of life have moral meaning. Sometimes referred to as *mutuality*, another component of care-based ethics views relationships as processes that are negotiated and collaborative in which all involved parties participate, choose, and act (Storch, Rodney, & Starzomski, 2004). Finally, there is recognition of the role of emotions in care-based ethics that is lacking in the objective stance of principlism. The basic argument against emotions as a moral guide is that they are unreliable and changeable. Little (1996) presented a counterview of the role of emotions in ethics, noting that emotions can lead us to attend to the “particulars” in a situation that can be helpful in recognizing an individual’s needs. Without this emotional connection, we could miss important information that distance obscures.

Thus, where one stands in relation to another is morally salient in care-based ethics, which aligns with many of the values of the nursing profession. Both virtue and care-based ethics provide another vision of ethics that draws attention to the moral agent, who he or she is as a person, and the specific circumstances and relationships in particular situations that also influence action and the priority of responsibilities.

## Cases in Ethical Reflection

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Rather than starting with abstract rules or theories, a clinical case is useful to illustrate the realities of healthcare practice. Arras (1994) presented a basic argument for the use of cases or narratives in ethical reflection: “I think all would agree that a complete story or history is a prerequisite to any responsible moral analysis. Before one can attempt to judge, one must understand, and the best way to understand is to tell a nuanced story” (p. 1004). The following case was selected for analysis because it does not specifically deal with a significant ethical issue, such as a life-or-death decision or the use of expensive or experimental therapy, but rather with a very pedestrian intervention—that is, whether or not to turn a

patient who is in bed. Because ethical issues sometimes get lost in urgent, high-technology cases, a part of routine nursing care that involves physical contact with a patient is examined so that subtle yet important ethical issues become salient.

## Case Study

Bessie Watkins is a 5 ft., 10 in., 70-year-old retired school teacher who was admitted to the hospice care unit of a small community hospital. She was diagnosed with metastatic cancer that had spread from her left breast to her spine and ribs. Single and living in her own home with her only sister, she was admitted to the hospital because she had become too weak to walk and could barely feed herself. Upon the advice of her personal physician, Miss Watkins had decided not to undergo chemotherapy. Her admission orders noted that she was in the terminal stages of cancer and was to be kept comfortable with narcotic medication per continuous IV infusion.

Miss Watkins had many friends on the unit. Staff and visitors delighted in her bright wit, charm, sparkling eyes, and stories. But as the cancer spread throughout her body, she would cry and beg the staff not to move her by turning her. Because she was tall and thin, her bony prominences became more pronounced as she became sicker. A special mattress was ordered to help prevent breakdown of her skin, but the staff still needed to turn her several times a day to prevent pressure ulcers and to change the bed linens. When they did, Miss Watkins cried out from the pain so much that the staff wondered if they were really helping this patient by their nursing interventions.

Finally, the staff met to decide what they should do. Mrs. Twomey, the head nurse for 4 years, insisted that Miss Watkins be turned at least every 2–3 hours for linen changes and for observation of her skin. After all, she pointed out, that was routine and minimal nursing care for all bed-ridden patients, and this was the standard of the unit. Any skin breakdown and its necessary treatment would be a very serious problem for Miss Watkins in her already severely compromised condition. Mrs. Hanks, a nurse's aide on the unit for almost 15 years and a long-time acquaintance of Miss Watkins, said that she could not stand to see this patient cry every time she was turned. She said that she would prefer that Miss Watkins's sedation be increased to reduce her pain and facilitate linen changes. Miss Benson, a recent graduate, voiced her opinion that the patient should have some say regarding her care. After all, she had terminal cancer, and not turning her would hardly make a difference in the overall outcome of her

illness. Mrs. Culver, the evening nurse, thought that her physician ought to be the one to decide how often Miss Watkins should be turned. Then, the nurses would not have to make a decision and could just follow his orders. The rest of the nurses strongly objected to this suggestion. Turning a patient, changing linen, and observing for skin breakdown are nursing measures, they argued, and they should decide together the appropriate nursing interventions for this patient. Could everyone be comfortable not turning Miss Watkins unless it was absolutely necessary? How should they decide? (Fry, Veatch, & Taylor, 2011, pp. 91–92)

## Discussion

The question that closes this case study is not “*What* should they decide?” but rather “*How* should they decide?” By starting with a “how” question, the nursing care team has already made an important decision: They have decided that Miss Watkins’ care is a communal decision that involves all members of the nursing team. The team members recognize their mutuality in caring for Miss Watkins, so the decision is collaborative, involving everyone who provides direct care to the patient. By so doing, care-based ethics is evident in the way the issue is handled. Additionally, another question is posed in the case study that focuses on the relationships that are an integral part of this patient’s care: “Could everyone be comfortable . . . ?” directs attention to what it means to live with a moral decision and the recognition that decisions have far-reaching effects on those concerned. The decision of whether or not to turn Miss Watkins has ethical implications because it has a direct impact on human well-being, there does not appear to be one clearly correct course of action, and informed and well-intentioned individuals can disagree about which course of action is correct. When reviewing a case, sometimes the tendency is to find holes in the clinical problem so that the ethical issue disappears. In this case, some might argue that the newest bed and mattress system to prevent pressure ulcers could eliminate the problem of turning. That may be true, but the problem of keeping Miss Watkins clean and dry and the pain that results from those actions would remain, as would the larger issue of the appropriate trade-offs between pain and comfort in the case of a dying patient.

In the case of Miss Watkins, one could ask what the traditional ethical principles have to offer. If the light shines on the principle of respect for autonomy, there are more questions than answers. At one point, Miss Watkins appeared to have been competent because the case described “her bright wit, charm, sparkling eyes, and stories.” When she was able to communicate, did anyone involve her in thinking about advance planning for her hospice care? Toward the end of the case, it seems that Miss Watkins is no longer capable of participating in her care and weighing the benefits or harms of turning her in bed as one of many decisions she might be asked to make. At this point, there is temptation to be judgmental about the evident lack of planning on the part of the staff involved in Miss Wat-

kins' care, but placing blame does little to remedy the present problem. However, this experience with Miss Watkins might encourage the nursing staff involved to think differently about how they interact with future patients and when to address the subject of end-of-life care.

The principles of avoiding harm and doing good are also at work in this case as the individuals discuss minimal and routine care and standards. Generally speaking, maintaining skin integrity is a sign of good nursing care. Somehow in Miss Watkins' case, the routine good of turning a patient and changing soiled linens has become an instrument of pain with questionable outcomes. Members of the nursing team expressed their own pain that resulted from hearing Miss Watkins cry out, but all healthcare workers know that some pain is to be expected when delivering treatment. What makes Miss Watkins' cries intolerable for the team members? Indirect references to fidelity to the patient are most clearly highlighted by the nurse's aide, Mrs. Hanks, who has known the patient for a long time. Does the length of her relationship to Miss Watkins lend more weight to her comments about what should happen? Fidelity also plays a part in admission to a hospice care unit that promises certain assurances about end-of-life care. Hospice care, whether provided in someone's home, a skilled nursing facility, or a hospital unit, "embraces a philosophy of caring, combined with the best medical knowledge and clinical skills to provide care that is both compassionate and competent. In selecting hospice care, a dying person chooses health care that focuses on comfort and function rather than on cure or prolongation of life" (Lynn, Koshuta, & Schmitz, 1995, p. 1157). Miss Watkins chose hospice care on the recommendation of her physician. Choosing hospice means that Miss Watkins valued comfort rather than cure or prolongation of life. She should be able to rely on the implicit promises of a hospice program to deliver care directed to comfort. The final core principle, justice, does not seem to play a major role in helping analyze the case unless there is a sense that the team is somehow discriminating against Miss Watkins. If any unfairness exists in the case, it would seem to be toward a positive inclination to do right by this patient who "had many friends." One then sees how justice could play a significant role in the treatment of a patient who did not hold such esteem in the nursing team's collective heart.

Other factors certainly are involved in the cases that do not fit neatly into the principlist approach. For example, the members of the nursing team represent various positions and assigned status. Cohen and Erickson (2006) reflected on how different values and principles can move the characterization of the problem in a specific direction: "How an individual nurse perceives and reacts to a patient care situation is a highly individualized process that depends on the individual's unique set of beliefs and values. What one nurse sees as an ethical conflict may not be seen as troubling by another nurse who is guided by a different set of principles and priorities" (p. 777). Additionally, the experience of the nurse will reframe the problem, as can be seen with the new nurse, Miss Benson, who emphasized the patient's role in decision making, as compared to the seasoned head nurse, Mrs. Twomey, who appeared to value following a specific standard of

care to avoid known harms (e.g., skin breakdown) regardless of the short-term pain to the patient. Miss Benson also argued that “not turning her would hardly make a difference,” which gives insight into her assumption about whether others would share her view of the benefits and harms in the case.

Several tenets of care-based ethics resonated in the comments of the members of the nursing team. They are concerned about Miss Watkins as a person they know and care about. As a retired school teacher who possibly spent much of her life in the small community in which she is now hospitalized, Miss Watkins’ connections to the nursing staff could be much more diverse than her present role as a patient. The case noted that Miss Watkins lived in her own home with her only sister, but there are no further references to this sister. It is unknown whether Miss Watkins and her sister were close or fought every day they lived together, nor if the sister was younger or older, sick or well, capacitated or incapacitated. It is only known that she is family. The sister may or may not be willing or able to participate in making decisions for her sister. One can assume that separation from her family and home is a drastic change in Miss Watkins’ life, as she did her best to stay at home as long as she could. Involving the sister in a way that makes sense for both of them would seem to be an important connection to restore or at least explore. As Nelson and Nelson (1995) noted,

In the midst of all the strangeness of illness or injury, alienated from ourselves and from the ongoing ordinariness of things, we can turn to our families for orientation to our new reality. The family’s mechanisms for maintaining selves are never so useful as here, when we first begin to gauge the effect of bodily catastrophe on who we are. (p. 46)

The presence of Miss Watkins’ sister will not necessarily solve the problem of whether or not to turn her as she lies dying, but it could make a dramatic difference in the quality of her dying. In addition to familial relationships, the relationships of the nursing staff to the patient and to each other are important. They are “standing” with Miss Watkins during this difficult time in her life, and they are working together to discuss how to make their actions “right.” Mrs. Hanks even uses the metaphor of standing when she relates that she “could not stand to see this patient cry.” Mrs. Hanks offered a sort of compromise resolution to the problem by suggesting increased sedation so that Miss Watkins would not be in pain when they turned her. This resolution takes care of the problem of pain and conforms to the standard nursing intervention for a bedridden patient, thereby fulfilling both moral obligations. Miss Benson would likely not share this view as she has already determined that turning is not providing enough benefit to outweigh the pain and thus is not a required intervention in this case.

Other questions remain that require careful balancing of principles as well as other ethical considerations that go beyond what principlism has to offer the individuals involved in Miss Watkins’ care. The broader guiding principles that follow in the next section present some possibilities of looking beyond what should be done to the deeper meanings of actions.

## A Broader Notion of Principles of Ethics

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The following is an overview of five ethical considerations that have relevance in analyzing ethical issues in clinical practice. These considerations bridge a variety of perspectives and do not fit neatly into any particular category or approach to ethics. The first broad principle again involves reflection on benefits and harms but with additional parameters.

### Proportionality in Clinical Decisions

When considering benefits and harms in the care of patients, it may be helpful to draw on the basic method of the Catholic tradition for resolving cases with complicated weighing of benefits and harms. Patients are at the center of this ethical focus that has gained traction in the secular world of healthcare ethics as well. Part Five of the *Ethical and Religious Directives for Catholic Health Care Services* states, “A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community” (United States Conference of Catholic Bishops, 2009, p. 31). The criterion of proportionality introduces the importance of intentionality when considering moral actions in addition to determining good and bad outcomes, some of which are intended whereas others are not. Proportionality argues that any evil caused by one’s actions first must not be intentional, and second, must be counterbalanced by a proportionate good. Generally speaking, turning patients who are bedridden to avoid the harm of pressure ulcers is good; however, in the case of Miss Watkins, there is a predictable harm or evil—in this case, pain—that results from turning her that is not intentional yet happens nonetheless. Is this unintentional pain counterbalanced by the good that turning accomplishes? It is important to step back from the specifics of the case and think about the benefits and harms from the perspective of achieving treatment goals for all patients.

First, there is the presumption that the value and dignity of every patient demand treatment that is based on broad goals of health care that include cure (when possible), stabilization, restoration of bodily functions or mental capacity, and comfort. The treatment choice should always be based on the patient’s best interest. Evidence of lack of proportionate benefit includes (1) the treatment would be futile, i.e., the patient would die regardless of the treatment, and the treatment merely serves to prolong the dying process, (2) “the potential for human relationship is non-existent or would be utterly submerged in intractable pain and/or the mere struggle to survive,” or (3) when curative care is not possible, comforting and supportive care should become the goal (Glaser, 1985, pp. 89–90). One could argue that admission to hospice care by default determines certain types of care as inappropriate. There could also be strong arguments that turning is a futile treatment in the case of a dying patient. The assumption is that

turning prevents pressure ulcers in dying patients, but is that assumption true? The nurses in Miss Watkins' case are not the only ones to ask questions about preventing and treating pressure ulcers in dying patients. If the nurses were to examine the literature on this topic, they would find a great deal of controversy. First, it appears that there are differences in the type of care provided depending on whether the goal is to prevent skin breakdown or to heal existing wounds. Also, a great deal of the effectiveness of nursing interventions depends on how close to death a patient is as well as other physiologic factors. As Hughes, Bakos, O'Mara, and Kovner (2005) noted, best practices for wound treatment in dying patients is a largely unexplored and complex topic.

Although there is not complete agreement, some research indicates that it is not possible to prevent pressure ulcers even with the most aggressive preventive care. Even if regular turning and skin care could indeed prevent skin breakdown, Miss Watkins and perhaps members of the nursing team might not agree with that goal of care. Comfort and support could take priority. A qualitative study of hospice directors and direct-care nurses regarding pressure ulcer treatment and prevention found that other goals may be more important to patients: "Comfort may supersede prevention and wound care when patients are actively dying or have conditions causing them to have a single position of comfort" (Eisenberger & Zeleznik, 2003, p. 19). The best care for Miss Watkins could be to leave her in a comfortable position and only provide care that keeps her clean and warm, with appropriate pain management when it is necessary to move her. Such a plan would be in line with the following admonition from ONS.

Dying people are cared for by compassionate, sensitive, and knowledgeable professionals who attempt to identify, understand, and meet their individual needs, particularly in the case of fear or a sense of hopelessness or loss of control. Alleviation of pain and other serious symptoms must be a key priority in providing quality palliative care. (ONS, 2010, p. 249)

### **Distinguishing Between Pain and Suffering**

Beyond balancing adequate pain relief, comfort, and possibly consciousness, the clinical case calls for the distinction between pain and suffering. Nurses are particularly situated in health care to be present to suffering. Even with careful and individualized assessment, planning, and treatment for pain in a dying patient, suffering can and often does occur. In Miss Watkins' case, she could not speak with words but communicated powerfully through her cries of pain. Her suffering also affected those who cared for her. As Fowler (2008) noted, "Suffering can make us acutely aware of our mortality and impotence, dashing our illusions of control and power, and yet it can move us to develop in new ways, ways that joy does not" (p. 274). The members of the nursing team were used to doing things to and for patients, but when a patient is dying, there is generally less to do regarding treatments and medications. When there is less rushing about and

“doing,” nurses have to face what is happening. They may lose the comfort of being in action and the sense of control it gives. What is required, then, is to be present to suffering. Fowler explained, “This presence is a presence in vulnerability—the vulnerability of the shared human condition—that, while it still retains identity boundaries, is open to an ontological change in both persons by virtue of human connectedness” (p. 276). The nursing team caring for Miss Watkins must accept not only her death but also their own vulnerability and limitations while carrying on with other patients and families. Dealing with suffering on the part of patients and health professionals has clear ethical implications and is an often-neglected yet important component of ethical analysis.

### **Disclosure, Informed Consent, and Shared Decision Making**

The time for discussion about treatment options and planning for care has passed for Miss Watkins. When she was able to participate, critical conversations did not seem to take place, which might have been helpful at this juncture in making treatment decisions that were in accordance with her wishes and goals. However, in most cases, the foundational principles of disclosing understandable information and engaging the patient and family in decision making are critical. As noted by Fletcher and Spencer (2005),

Healthcare, particularly when alternative treatments are possible, inevitably involves issues of values, which do not lie within the domain of medical knowledge. How can clinicians determine, in all cases, what is in the best interest of patients without consulting patients and adequately disclosing what they need to know to make decisions? (p. 13)

Miss Benson noted this important aspect of the basic underlying ethical components of respect for autonomy in her comments. If possible, patients should be involved in discussions and decision making, and decisions should be revisited if the situation changes. Additionally, many small but important treatment questions should be addressed even if the established goal is comfort. Then, with this foundation of shared decision making, even when a patient can no longer participate in decisions, the treatment team has insight into what the patient would want. As Cain and Hammes (1994) stated, “Information that can be considered by patients, families and their physicians at a time when impending crisis management is not looming large represents a greater respect for encouraging accurate expressions of wishes and values” (p. 162).

### **Fulfilling Professional Responsibilities and Integrity**

The process of restoring health, wholeness, or healing depends on the trust of patients and their families and the trustworthiness of health professionals. Clinicians owe patients not only their competency but also their dedication to clear and sustained communication. Additionally, health professionals owe patients a caring

presence. All of this sounds very simple, yet in practice it can be very difficult for health professionals to care for someone who has a life-limiting illness or who is suffering. Not only is it important to “do” the right thing, but the manner in which a health professional interacts with a patient and family is equally important.

There is specific expression of concern in the clinical case about the integrity of those involved in Miss Watkins’ care when they ask, “Could everyone be comfortable . . . ?” What sort of treatment plan and course of care can everyone involved in Miss Watkins’ care live with in the immediate future and after her death? Although not the case here, sometimes clinicians are asked to provide treatment that is in opposition to their consciences. Patients have the right to refuse treatments, but they do not have the right to request treatments that are inappropriate or that would undermine the health professional’s integrity. ANA’s *Code of Ethics for Nurses* supports this obligation in Provision 5, which states, “The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth” (ANA, 2015, p. 19). The idea of integrity bridges the personal and professional elements of identity. Integrity is informed by experiences that reshape what it means to be a good health professional.

### **Considerations of Power**

The patient and family are always in a position of diminished authority because of illness, injury, less education, and position within the healthcare system. Sharing understandable information and allowing adequate time and dialogue for understanding are ways to balance power differentials. Another way to equalize power is to consider the specific implications of the patient and his or her family so that care is personalized. This case involves specific nursing interventions unlike other interventions that belong to other disciplines or are shared, such as end-of-life treatment decisions that include do-not-resuscitate orders or withholding or withdrawing artificial nutrition and hydration. When Mrs. Culver suggested shifting responsibility to the physician for the decision so they could “just follow orders,” there was immediate pushback by her peers. The specific intervention is under the nurses’ purview. Therefore, it was up to “them” to decide, and they resisted relinquishing their power to a higher authority. If nurses claim power, then they need to accept the responsibility that goes with it, including being competent in all aspects of the literature on skin care and dying patients as well as the ethical basis for decisions to withhold standard therapy.

Other members of the healthcare team are in positions of diminished authority, such as nursing assistants and aides. Such individuals also bear witness to patients’ suffering and may be in a unique position to notify professionals higher up on the organizational ladder about their concerns. In fact, nursing assistants often feel morally responsible to call attention to issues because of the intimate care they provide and the relationships that are established from such involvement with patients

(McClement, Lobchuk, Chochinov, & Dean, 2010; McClement, Wowchuk, & Klaasen, 2009). In Miss Watkins' case, the nurse's aide, Mrs. Hanks, not only is part of the discussion but feels empowered enough in the group to speak up and offer a possible resolution to the conflicts in the patient's care. By minimizing power differentials, it becomes possible to hear and respect every voice, which adds to the probability of reaching a sound decision that the team can accept.

## Conclusion

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Ethical principles can be a source of guidance for oncology nurses as they steer a course through complicated clinical dilemmas. However, the moral life is more than making discrete decisions but encompasses how nurses live and think about these important ethical matters. To avoid a too-narrow view of ethical discernment, broader concepts of principles, such as proportionality, considerations of power, and facilitating shared decision making, are necessary to consider the variety of issues at play. The question of how to do good for a patient in oncology nursing leads to other more profound questions that take into account the wider ethical considerations of caring for others within a complex healthcare delivery system and the broader society in which it exists.

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