ETHICS and ETHICAL ISSUES
For
Licensed Midwives

CONTACT HOURS: 2

DESCRIPTION:

This course will provide the learner with an overview of various ethical principles; the evolution of ethical thought throughout history; ethics in healthcare; ethical dilemmas and ways to resolve them; commonly occurring and most recently encountered ethical issues in healthcare, including opioids at the end of life, euthanasia and assisted suicide, extubation, and do not resuscitate; and available resources that aid in the facilitation of ethical decision-making.

OBJECTIVES:

At the conclusion of this course, the learner will be able to:

1. Define and detail various ethical principles and concepts, such as autonomy, beneficence, nonmaleficence, and justice.
2. Relate the historical and current evolution of ethical thought including milestones, such as the Hippocratic oath and the American College of Nurse-Midwives' Code of Ethics.
3. Articulate ways in which ethical dilemmas can be resolved and methods of ethical decision-making.
4. Detail some commonly occurring ethical issues and resources, including human resources that can be used to make ethical decisions.

INTRODUCTION

Ethics and ethical practice has, and continues to remain, one of the most important paramount decision-making frameworks in healthcare as well as in other professions. Many professions and professionals are often in a position where they influence the lives of others. This position makes it necessary for them to accept the responsibility of acting ethically and in the interest of those they serve. Ethically, we are held accountable for our acts of omission and commission.

Professions have ethical codes in order to thoroughly, and as parsimoniously as possible, address all possible ethical concerns in the profession. Ethical codes are formal statements about commitments to the good. They contain values and guide the practice(s) of those in the profession or business area.

Accountants, attorneys, real estate brokers, and government employees have codes of ethics that they must adhere to. Accountants are held accountable for honesty and honest accounting practices; real estate brokers are held accountable for disclosures regarding problems and potential problems, such as asbestos, lead and sink hole risks; attorneys are ethically bound to maintain confidentiality and privileged communication regarding some matters; and government employees are ethically bound to avoid any conflicts of interest. Recently, corporate ethics has become a national focus of attention, especially after the Enron Corporation collapse and their faulty accounting systems.

The ultimate purpose of ethical codes in the healthcare industry is to protect the rights and safety of the healthcare consumer. Healthcare professionals must act ethically and adhere to their own professional codes of ethics. (National Council of State Boards of Nursing, 1996)

ETHICS: BASIC PRINCIPLES AND CONCEPTS

Ethics *is defined as* "the discipline dealing with what is good and bad and with moral duty and obligation; a set of moral principles or values; a theory or system of moral values; the principles of conduct governing an individual or a group <professional *ethics*>; a guiding philosophy" (Merriam-Webster,2001).

Ethics is a body of knowledge containing values that are held by individuals of groups. Ethics and ethical codes in healthcare reflect four basic ethical principles, or underlying themes, that serve to organize the body of medical ethics and medical ethical decision-making.

These four ethical principles are:

- Autonomy,
- Beneficence,
- Nonmaleficence, and
- Justice.

Autonomy *is "the quality* or state of being self-governing; *especially* **:** the right of self-government; self-directing freedom and especially moral independence; a self-governing state" (Merriam-Webster, 2001).

Beneficence is defined as "the quality or state of being beneficent" (Merriam-Webster, 2001).

Nonmaleficence is best described as doing no harm. The Hippocratic Oath is an excellent example of how, historically, ethics and ethical principles have been in the healthcare profession throughout the ages. The Hippocratic Oath can be read below in Table 1.

Justice is defined as "the maintenance or administration of what is just especially by the impartial adjustment of conflicting claims or the assignment of merited rewards or punishments; the administration of law; *especially* **:** the establishment or determination of rights according to the rules of law or equity; the quality of being just, impartial, or fair; the principle or ideal of just dealing or right action; conformity to this principle or ideal; the quality of conforming to law; conformity to truth, fact, or reason; correctness "(Merriam-Webster,2001).

Autonomy

The word autonomy is derived from the Greek word for self-rule. In reference to healthcare, autonomy is strongly linked to the client's right to decision-making and self-determination. All competent adults have the basic freedom to choose and make choices.

Patients and residents have a right to informed consent and informed refusal. They have the basic right to autonomous, knowledgeable decision-making and the ability to make choices, whether or not the healthcare provider(s) agrees with them or not.

Adults have the right to make decisions when they are of majority age, that is, at least 18 years of age, and they are deemed mentally competent to do so. Minors, on the other hand, are not legally able to make a decision about what care they will or not receive until they reach the age of 18 or they become a legally emancipated minor. Parents generally make legal decisions for minors. In some cases, a court appointed guardian makes these decisions, in the absence of a parent.

The adult consumer of healthcare services, or their surrogate, proxy, decision maker, has the right to consent to care and they also have the right to refuse any aspect of care or a treatment. These autonomous decisions are based on the individual's own unique values and beliefs; they are not based on what the healthcare provider feels is best for them. Self determination and autonomous decision-making must be ethically upheld by all healthcare professionals at all times.

Beneficence

Simply stated, beneficence is doing good. Beneficence is doing the ethically correct thing. It reflects an individual's intentional acts, not errors and mistakes. Beneficence aims to promote the well being of others, not self. These intentional acts take into serious consideration the welfare of others. It is the welfare of others that is of greatest importance.

Beneficence challenges and ethical dilemmas in healthcare occur when it is not totally clear about what is truly good for a particular patient. Patient and resident needs are generally complex and approaches to care are numerous and varied. Many dilemmas arise because of these complexities and other factors.

The multidisciplinary healthcare team sometimes has difficulty arriving at a plan of care that is best for the patient and even then, not all members of the team may be in agreement about what course of treatment or care is best. Additionally, the autonomous decisions of the patient may make the "best" treatment options not feasible because the patient, resident or surrogate, proxy, decision maker has expressed the fact that they do not want a particular treatment or intervention. Lastly, the team and patient or resident may collectively agree to what is best, but this option is not available or accessible to them and/or the option may not be legally permissible. For example, euthanasia is not legally permitted in our country. Any patient requests for euthanasia, therefore, cannot be supported because it is illegal. The healthcare team cannot agree to, or support, this option despite their own personal beliefs that euthanasia should be a legally acceptable and that this is the "best" option, especially when a patient or resident is using their right to self determination by expressing a desire for it.

Nonmaleficence

Nonmaleficence literally means, "do not harm". Maleficence is defined as “doing harm”. Nonmaleficence and beneficence are closely related, particularly in healthcare ethics, because many treatments and procedures have both benefits (beneficence) and risks for harm. Some of these risks can cause patient harm and pain (maleficence).

For example, a client under our care may choose to be intubated. Prior to consenting, the individual was correctly and completely informed about intubation, its benefits and its risks, including those associated with infection. Alternatives to this intubation were also discussed with the patient or proxy decision maker, as appropriate. If this patient chooses to have the intubation and gets an infection as a result of it (maleficence), it is not considered unethical because the patient autonomously decided to have this invasive treatment after they were advised of the risks associated with this treatment and because the harm, or infection, was not done intentionally by the doctor, licensed midwives and other healthcare professionals.

Justice

The principle of justice entails fairness, impartiality, and justness. Challenges in the area of justice are numerous in the healthcare industry, particularly because fair and impartial access to care is sometimes not possible due to the constraints associated with healthcare dollars and the allocation of limited resources. These kinds situations are generally highly complex and difficult to resolve using justice alone as the ethical framework for decision-making.

Other healthcare situations, however, are easily addressed in terms of the principle of justice. Providing the same level of care and the same level of quality for all those in our care, without discrimination, is straightforward and quite simple to ethically accomplish.

THE HIPPOCRATIC OATH

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to

give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot. What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Scarborough, John. "Hippocrates." *World Book Online Reference Center*. 2005. World Book, Inc. 15 Jan. 2005. <http://www.aolsvc.worldbook.aol.com/wb/Article?id=ar257540>.

ETHICS IN HEALTHCARE AND NURSING: HISTORY AND CURRENT STATE

Historically, the first documented sign of ethics in healthcare was the Hippocratic Oath that was discussed above in the context of nonmaleficence. Florence Nightingale continued the development of ethics for nurses as she promoted ethics throughout her practice and within the schools of nursing that she was instrumental in running. The need for ethics and ethical practice in nursing and healthcare continues from these early beginnings to the current day.

The American College of Nurse-Midwives (ACNM), founded in 1955, is the professional organization for certified nurse-midwives and certified midwives. This organization serves midwives who work in a variety of healthcare and educational settings. Their Code of Ethics specifically states the ethical code for this profession, as below.

Code of Ethics of the American College of Nurse-Midwives

"The Code of Ethics sets forth values, ethical principles, and standards to which professionals aspire and by which their actions can be judged. The purpose of this code is to identify the moral obligations of all certified nurse-midwives and certified midwives inherent in their professional roles. Specifically, midwives are obligated to support and maintain the integrity of the profession of midwifery in order to promote the health and well-being of women and newborns within their families and communities.

Midwives in all aspects of professional relationships will:

1. Respect basic human rights and the dignity of all persons.

2. Respect their own self worth, dignity, and professional integrity.

Midwives in all aspects of their professional practice will:

3. Develop a partnership with the woman in which each shares relevant information that leads to informed decision making, consent to an evolving plan of care, and acceptance of responsibility for the outcomes of their choices.

4. Act without discrimination based on factors such as age, gender, race, ethnicity, religion, lifestyle, sexual orientation, socioeconomic status, disability, or nature of the health problem.

5. Provide an environment where privacy is protected and in which all pertinent information is shared without bias, coercion, or deception.

6. Maintain confidentiality except where disclosure is mandated by law.

7. Maintain the necessary knowledge, skills, and behaviors needed for competence.

8. Protect women, their families, and colleagues from harmful, unethical, or incompetent practices by taking appropriate action that may include reporting as mandated by law.

Midwives as members of a profession will:

9. Promote, advocate for, and strive to protect the rights, health, and well-being of women, families, and communities.

10. Promote just distribution of resources and equity in access to quality health services.

11. Promote and support the education of midwifery students and peers, standards of practice, research, and policies that enhance the health of women, families, and communities." (American College of Nurse-Midwives, 2004).

ETHICAL DILEMMAS

An ethical dilemma arises when two or more of the four (autonomy, beneficence, nonmaleficence, and justice) ethical principles are in conflict with one other. For example, when what is good is not justly and fairly distributed or when autonomy is in conflict with beneficence.

Ethical dilemmas disrupt internal and external harmony and homeostasis. They are uncomfortable and often a source of disagreement and debate among members of the healthcare team. For example, an ethical dilemma relating to who gets and who does not get a particular treatment or an organ, can be a source of great consternation and frustration. Allocating limited healthcare resources is an omnipresent challenge in our industry.

Case Study

Arnold is a 53-year-old businessman and a father of 4 children. He is the sole source of family income and is the CEO of a Fortune 500

company. Jane is a 23-year-old developmentally disabled woman without children and without any health insurance. Her medical costs are covered with Medicaid and she is presently living in one of her state's long-term care facilities.

Both individuals are in need of a liver transplant. Both are acceptable candidates. Jane has been waiting for 2 years and Arnold for 1 ½ years.

A young male has died in an automobile accident and his liver has been donated. He is a compatible donor to both Jane, first on the list, and Arnold, 2nd on the list.

Who should get the liver, using the basic ethical principle of justice? Who should get the donated liver, using the basic ethical principle of beneficence?

Ethical dilemmas, although challenging, can be resolved. Ethical dilemmas are best resolved on a case-by-case basis within the context of the unique patient and their unique needs and by using the four basic ethical principles for analysis and decision-making.

The resolution of ethical dilemmas is also best accomplished by a group, rather than one individual. Collective analysis and decision making promotes diverse thinking and often a decision that can be ethically and comfortably accepted by all of those involved in the process.

ETHICS COMMITTEES

Most healthcare facilities now have ethics committees to address ethical dilemmas. Attend a meeting at your facility, especially if you have never attended one before. Ethics committees typically consist of a diverse group of healthcare professionals from different disciplines. Most often there will be representatives from medicine, nursing, pharmacy and nutritional services. Many also have an administrator, a chaplain and a healthcare consumer as members. An ethicist consultant is sometimes added to the group composition when the group is having difficulty resolving a dilemma without the help of an expert ethicist to consult with.

Ethics Committee policies and procedures vary from facility to facility, however, ones that make provisions for the following are the most helpful.

- Ethics committee members should be educated about ways to analyze ethical dilemmas and about sound ethical decision-making. Ethical dilemmas should be analyzed with a systematic exploration of ethical values according to their level of importance until the two or more ethical principles that are in conflict with each other become balanced. After analysis a consensus should be obtained in terms of the decision making process.
- Staff should have formal and informal ways to articulate their ethical concerns. Ethical dilemmas occur at the bedside not in administrative offices. Committees that are not responsive to all levels of staff and their concerns cannot be effective in fulfilling their roles and responsibilities.
- Staff should be able to expect a decision from the ethics committee in a timely manner. Ethical dilemmas are a source of stress for individuals and groups. Often, they are divisive. They also threaten the safety and well being of the patient. Staff should be able to expect that an ethical decision is made in a prompt and timely manner so that the dilemma can be resolved and patient care decisions can then be made and carried out without conflict. Additionally, it is usually helpful to have the staff member attend the meeting during which their dilemma is analyzed and resolved. They will be able to add to the discussion in terms of the unique situation and will also benefit from the learning and personal growth they acquire as a result of their participation.
- Ethics committees should educate members of their facility about ethics, ethical dilemmas, ethical decision-making, the role of their ethics committee and how to communicate an ethical concern or dilemma.

Ethics committees are an excellent resource for licensed midwives and all other healthcare professionals.

COMMON ETHICAL ISSUES

Inadequate Staffing

Inadequate staffing and unsafe staffing levels are a matter of grave concern. Some states, for example California and Florida, now have

minimum staffing laws to prevent the problems associated with inadequate and unsafe staffing. Although these laws have somewhat helped, they have not eliminated the problem altogether.

What should a licensed midwife, or other healthcare provider, do when they believe that staffing is not adequate enough to safely and effectively meet the needs of the patients that they are caring for? Should they refuse the assignment? Should the licensed midwife accept the assignment but pursue the matter in a formal and prompt manner? Should they just ignore the problem and do the best they can do?

The answers to these questions are not simple and easy. Inadequate staffing is a complex problem without simple solutions. Unsafe staffing can be a sporadic and rare occurrence, one that results from someone calling in sick or it can be an ongoing problem with no apparent efforts underway to correct it.

Ethically, the licensed midwife must address inadequate staffing in order to protect the patients and their rights to safety, freedom from harm and quality care. Ignoring the problem not only places the licensed midwife in a position of legal liability, it is also not ethical. Ethically, the licensed midwife must uphold the principles of beneficence and nonmaleficence. The licensed midwife's duty to promote the well being of others (beneficence) is not being fulfilled and the licensed midwife's duty to do no harm (nonmaleficence) is also not being fulfilled.

Patients suffer harm and a lack of the care they are entitled to as a result of inadequate and unsafe staffing levels. Although inadequate staffing is not an ethical dilemma with two or more ethical principles in conflict, it is a frequently occurring ethical issue because one or more of the four principles of ethics are not upheld. Licensed midwives, and other healthcare providers, must report staffing concerns to their supervisor and then up the chain of command until the situation is rectified. Yes, it is true that your actions may lead to some repercussions, nonetheless, it is your ethical responsibility to do so.

Inappropriate Doctor's Orders

Inappropriate doctor's orders are also a frequently occurring ethical issue. What should a licensed midwife, or other healthcare professional, do when they believe that a doctor's order is not

appropriate for the patient? Should they just ignore the order? Should they just carry out the order because the doctor ordered it?

Healthcare providers, using profession judgment, should know what doctors' orders are and are not appropriate based on the current condition of the patient. They must question an order when they suspect that it is inappropriate. A questionable order must never be carried out until it is clarified and deemed appropriate by the person carrying it out. To carry out an inappropriate order jeopardizes the ethical principles of beneficence and nonmaleficence. Similar to unsafe staffing levels, this is an ethical issue rather than an ethical dilemma with two or more competing ethical principles. To carry out an inappropriate order is simply unethical.

The first thing that a licensed midwife, or another professional, must do when they are given an order to do something that is inappropriate, illegal or unethical is to NOT follow the order. Communicate with the person giving the order, and document that conversation as well as your rationale for not following the order. Clearly communicate, and document the patient's current condition and why the order is not consistent with the patient's current condition. Communicate with your supervisor and follow further up the chain of command, or the channel of communication, until the inappropriate order is discontinued or it becomes apparent to you that it is indeed appropriate and necessary. To do otherwise is to jeopardize the well being of the patient and perhaps cause harm (maleficence). Yes, your questioning actions and your refusal to follow the order may lead to some repercussions, nonetheless, there are no other options. It is your professional, ethical responsibility to do good and to do no harm.

Euthanasia and Physician Assisted Suicide

Euthanasia and physician assisted suicide are commonly occurring and recent emergent ethical issues, ones with a tremendous amount of lively ethical debate on the international, national and local frontier. These issues are highly complex with religious, legal and cultural implications.

Those that support euthanasia and physician assisted suicide feel that quality of life and the right of an individual to self determination must be addressed with these alternatives, especially when the availability of so many life saving and life supporting interventions tend to prolong a life with little or no quality and when a person chooses to die rather than live. Those who argue against euthanasia and physician assisted

suicide believe that they are immoral and equivalent to murder. They also argue that euthanasia and physician assisted suicide can lead to the eradication of people viewed by society as not having a satisfactory quality of life. For example, some believe that euthanasia can lead to the elimination of developmentally disabled people once it is legally acceptable.

Voluntary euthanasia can be defined as the intentional act of ending a life at the request of a competent person who wishes to die. Involuntary euthanasia is defined as the intentional ending of someone's life without the request of a competent person. Euthanasia is also referred to as "mercy killing".

Physician assisted suicide is a similar concept, but it is slightly different. Physician assisted suicide is defined as a person ending their own life with the assistance of a physician. Typically, this assistance consists of the provision of medications, which the person can use to end their life when they decide to do so. Physician assisted suicide involves a physician making the death available but they do not serve as the direct agent, whereas, there is a direct agent, such as a physician or physician or another healthcare professional, that is involved with voluntary and involuntary euthanasia.

In 1994, the American Nurses Association (ANA) published a position paper entitled "Ethics and Human Rights Position Statements: Active Euthanasia, in which it addressed the issue of active euthanasia. The ANA does not consider voluntary or involuntary euthanasia ethical.

Euthanasia is also not permitted by law in the United States even if this action can be viewed as compassionate and supportive of the patient's wishes, either explicit or implicit. It is not legal.

The American Nurses Association (ANA) has, however, addressed some commonly occurring issues of ethical concern at the end of life, including the need to provide comfort even when comfort measures result in the cessation of some basic bodily functions, such as respiration. This guidance can serve as the framework for ethical decision making for all healthcare professionals, including licensed midwifes.

The ANA also ethically supports the cessation of hydration and nutrition, and the withdrawal of and withholding of resuscitation and other life sustaining measures, when chosen by the patient or surrogate decision maker in the absence of the patient's wishes.

The ANA, in support of the patient's need for comfort at the end of life, does encourage the implementation of pain management regimens even if these interventions hasten death. However, such interventions cannot be employed for the sole purpose of ending a life. (American Nurses Association, 1994; American Nurses Association, 2001).

Fins (2000) has also addressed the issue of opioids. According to Fins, St. Thomas Aquinas, an ethicist, introduced the ethical doctrine of double effect. Double effect differentiates between interventions that are intended to relieve suffering, like opioids, and interventions that intentionally hasten death, such as physician assisted suicide. Legal and illegal interventions as well as ethical and unethical interventions relating to opioid use at the end of life are often hinged on the double effect doctrine. (Fins, 2000)

"A nurse's role with regard to a terminally ill patient encompasses promotion of comfort and an optimal dying experience and extends through the continuum of life through death. Careful assessment and management of pain should be the principal goal of a palliative care plan." (American Nurses Association, 2001)

The ANA position statement, *Promotion of Comfort and Relief of Pain in Dying Patients* (2001), explores the issue of pain control in the terminally ill, again providing guidance to all healthcare professionals. The statement makes two important points:

- "Pain relief and the promotion of comfort as primary acts are hallmarks of professional nursing practice.
- The possibility of hastening death through the acts of promoting comfort and alleviating pain is a possible consequence of the primary act and is therefore ethically justified." (American Nurses Association, 2001)

"Many factors in a patient's personal profile should be considered when administering potentially lethal doses of medication. These include the existence of a living will, cultural background, family influences, and the patient's desires. The appropriate consideration of these factors necessitates reciprocal relationships among physician, nurse, patient (if able), and family, in which there is open discussion of all parties' concerns and needs.

Pain relief, facilitation of comfort, and an optimal dying experience must be differentiated from two unethical means of ending life, active euthanasia and assisted suicide. These acts stand in conflict with the ANA's *Code for Nurses with Interpretive Statements, 1985,* which serves as the main ethical resource for the guidance of nursing actions." (American Nurses Association, 2001)

"*The Pain Relief Promotion Act* (H.R. 2260), introduced in Congress in 1999, includes a troubling provision allowing the Drug Enforcement Agency to investigate the intentions of health care professionals who prescribe medication. The ANA opposes this legislation, believing it would create a barrier to effective palliative care and prevent patients from receiving end-of-life treatment. The ANA has urged Congress to vote against the proposed legislation and to focus more attention on federal support for pain management and palliative care." (American Nurses Association, 2001).

Other Ethical Issues That Affect the Role of the Licensed Midwife: Extubation and DNR

Two other commonly encountered ethical issues that impact the licensed midwife include:

- The cessation of life sustaining intubation and ventilatory support, particularly with the newborn
- Do not resuscitate (DNR) orders

The *cessation of life sustaining intubation* and ventilatory support is one of the most difficult decisions made during the perinatal period. Often, the decision to extubate a patient is the result of complex medical decisions about the patient's current state, quality of life and prognosis. This decision may be accompanied by family debate and disagreement as well as the utilization of an ethicist, ethics committee and/or a member of the clergy. Ideally, decisions such as the cessation of life sustaining intubation and ventilatory support, are pre-established in the individual's advance directive or living will, however, this is often not the case, especially when this kind of intervention is not anticipated. For example, multiple complexities arise when the person is suddenly at the end of life or in a vegetative state as the result of an automobile accident or another unexpected event such as cardiac arrest during childbirth.

Causal relationships between the mechanical ventilation and death are examined during ethical debates regarding this life

sustaining intervention. Healthy people do not die when a ventilator is removed. "Only dying people will die when life support is removed, not those of us who are healthy. Thus the removal of a ventilator only leads to the death of patients who have an underlying disease process that requires ventilatory support. The mere act of extubation will not cause death in an otherwise healthy patient once awakened from sedation. Although the removal of the ventilator is necessary to cause the death, it alone is not always sufficient to cause a patient's death. In this way, the removal of the ventilator contrasts with physician-assisted suicide, which does not hinge upon the patient's underlying condition." (Fins, 2000)

Advance directives and *do not resuscitate orders (DNRs)* have greatly assisted healthcare providers regarding these kinds of interventions, however, some issues still remain. For example, should a patient with a DNR order and a correlate advance directive (negative right) be resuscitated during a surgical procedure that is palliative in nature. " Consider a patient with advanced colon cancer who has an intestinal obstruction. All palliative care measures have been unable to relieve the painful obstruction. A surgical consultation is sought for the possibility of a diverting colostomy. The surgeon agrees that the patient would benefit from a colostomy but is reluctant to take a patient with a DNR order to the operating room. Trained in the American medical context and conditioned to understand the importance of respecting a competent treatment refusal, she or he finds that a DNR order in the operating room is confounding. How is it possible to respect this inviolable negative right while exposing a patient to the risks of surgery, intubation, and even iatrogenic cardiac arrest?… If the patient dies during the procedure, death is an unintended side effect of the surgery, which was designed as a palliative. The implication is clear: surgical palliation and a DNR order are not mutually exclusive when the goals of care are clear and when we avoid judging palliation against curative expectations." (Fins, 2000)

ETHICAL RESOURCES

Websites

The American Society for Bioethics and Humanities
http://www.asbh.org/

American Society of Law, Medicine & Ethics

http://www.aslme.org/

Center for Biomedical Ethics at Case Western Reserve University

http://www.cwru.edu/med/bioethics/bioethics.htm

Center for Biomedical Ethics at Stanford University

http://scbe.stanford.edu//

Center for Ethics and Humanities in the Life Sciences at Michigan State University

http://www.bioethics.msu.edu/

Center for Ethics in Health Care (Oregon Health Sciences University)

http://www.ohsu.edu/ethics/

Center for Medical Ethics and Health Policy at Baylor College

http://www.bcm.edu/ethics/

Do No Harm; The Coalition of Americans for Research Ethics

http://www.stemcellresearch.org/

International Bioethics Committee (part of UNESCO)

http://portal.unesco.org/shs/en/ev.php-URL_ID=1372&URL_DO=DO_TOPIC&URL_SECTION=201.html

Kennedy Institute of Ethics

http://kennedyinstitute.georgetown.edu/site/index.htm

National Bioethics Advisory Commission (U.S.)

http://www.bioethics.gov/

National Catholic Bioethics Center (U.S.)

http://www.bioethics.gov/

ETHICS GLOSSARY

Advance directives. Instructions (usually written) from a competent individual that stipulates the forms of medical treatment to be provided by caregivers and/or designates someone to act as a proxy should the person at some future date lose decision making capacity. Living wills and durable powers of attorney for health care documents are common examples. Legal provisions vary from state to state.

Autonomy. 1) Derived from Greek words meaning "self rule." Referring to the patient's right of self-determination concerning medical care. Autonomy may be used in various senses including freedom of action, effective deliberation, and authenticity. It supports such moral and legal principles as respect for persons and informed consent. 2) Making decisions for oneself, in light of a personal system of values and beliefs.

Beneficence. The state or act of intentionally doing or producing good. The principal of beneficence involves duties to prevent harm, remove harm, and promote the good of another person. The obligation of health care professionals to seek the well-being or benefit of other patients. Duties of beneficence concern the welfare of others.

Competent. A legal concept that describes people who are able to make decisions for themselves. Minors are presumed to be incompetent, except under certain specified conditions. The corollary medical-ethical term is *decisional capacity.*

Confidentiality. The professional-client promise not to reveal information without consent.

Durable power of attorney for health care. An advance directive that goes into effect in the event that a patient who has completed such a document loses decisional capacity. Allows an individual to name a person(s) who is empowered to make health care decisions when the individual becomes incapacitated.

Emancipated minor. A teenaged minor, who is legally, independent of parental control and who can thus give informed consent to medical treatments.

Ethics committees. An. interdisciplinary group that deals with conflicts of values in patient care in acute and long-term settings. Such committees discuss policy issues (e.g., regarding withholding and withdrawing of life-sustaining treatments).

Euthanasia. The act of either permitting a person to die or intentionally ending a person's life, generally rooted in motives of mercy, beneficence, or respect for patient dignity.

Informed consent. The legal and ethical requirement that no significant medical procedure can be performed until the competent patient has been informed of the nature of the procedure, risks and alternatives, as well as the prognosis if the procedure is not done. The patient must freely and voluntarily agree to have the procedure done.

Nonmaleficence. The state of not doing harm or evil; see also beneficence.

Privileged communication. Information communicated to an attorney, physician, spouse, or counselor that may not be revealed, even in court, without the consent of the person who made the statement.

Proxy consent. Voluntary informed consent given on behalf of another who is for some reason incapable of giving it for himself or herself.

(Howard University School of Medicine Program in Clinical Ethics, 2005)

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