Study Guide

Code Gray

Ethical Dilemmas in Nursing
Study Guide to the film

*Code Gray: Ethical Dilemmas in Nursing*

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Introduction

In this 26-minute documentary film, nurses in a variety of care settings confront and attempt to deal with serious ethical dilemmas which affect their patients. The film’s four sequences illustrate dilemmas involving the ethical principles of beneficence, autonomy, justice and fidelity. Each incident raises a variety of issues and offers the possibility of a range of responses. None of the incidents is resolved. Rather, viewers are stimulated to debate the issues and apply their own values and ethical approaches.

This study guide is intended to help teachers and discussion leaders use Code Gray to heighten awareness of nurses’ ethical obligations and problems, and to illustrate the application of ethical principles to actual practice. It will also help to stimulate an examination of the social contexts within which ethical dilemmas arise.

Background

The field of nursing has undergone profound changes in recent decades. Nurses today occupy a pivotal position in the ever-growing healthcare industry: of all providers, they are the ones most directly involved in the day-to-day delivery of care to the patient, and are responsible for mediating between patient, doctor and institution.

Because of their pivotal role, nurses are confronted by radically conflicting loyalties, responsibilities and expectations, often in situations where the lives of their patients are literally at stake. They are faced daily by ethical conflicts for which their education and training have poorly prepared them, and for which they receive little recognition or support from the institutions which employ them.

Of course, nurses are not alone in confronting the moral conflicts created by changes in the technology and social structure of healthcare delivery. Physicians and administrators, and patients and their families as well, must deal with decisions and options that would have been almost inconceivable a few decades ago. Yet the ethical dilemmas faced by nurses are unique in several respects. They have received far too little attention.

- Rapid staff turnover and “nurse burnout” stem not simply from low wages or limited social status, but more fundamentally from the tension between what nurses believe they should be doing and what they actually do in day-to-day practice. The nursing crisis is thus, at its core, an ethical crisis.

- Because of their dual position as professionals and as employees, problems of ethical decision making are particularly difficult for nurses.

- Because of their greater degree of patient contact, the problems of nurses are of particular importance to the consumer of health services.

- While general issues of biomedical ethics have received widespread discussion, little attention has been focused on the particular situation of nursing. There are almost no materials available on ethical issues in nursing.

Synopsis of the Film

Code Gray: Ethical Dilemmas in Nursing is a 26-minute color documentary film consisting of four sequences focusing on some of the most typical ethical dilemmas arising in bedside nursing in institutional settings.

- In Case 1, the Primary Nurse and her Associates in the nursery face conflicts among them over the proper nursing care for a hydranencephalic newborn.

- In Case 2, the Registered Nurses and Licensed Practical Nurses staffing a rural nursing home must weigh the ethical considerations involved in deciding whether to apply mechanical and chemical restraints against the apparent wishes of their residents.

- Case 3 takes place in a busy general intensive care unit, where the Charge Nurse and other health team members debate their reasons for choosing to give more or less nursing care to particular patients – and for deciding which patients to keep or to transfer – in circumstances where there are neither enough nurses nor enough beds and equipment to give all patients ideal care.

- Finally, in Case 4, a nurse reflects on the difficulties of caring for a dying woman, and on the conflict between her loyalties to the patient and to the patient’s family.

Four principles of ethics (beneficence, autonomy, justice and fidelity) are particularly pertinent to the moral analysis of these four cases. The relevant principle is briefly defined at the beginning of each segment, to aid the viewers’ understanding of the ethical questions and obligations in the situation portrayed.
Suggested Uses

Code Gray has been used successfully in a wide variety of educational and service settings. It is an invaluable starting point for discussion about nurses and nursing practice, as well as about ethics. It is appropriate for baccalaureate, diploma, associate, and vocational programs in nursing, including nurse practitioner training, graduate programs, and continuing education. It can be used effectively in general philosophy, ethics, psychology and sociology classes, and in training programs for non-nurses such as chaplains, social workers, physicians, psychologists, therapists and technicians who will be caring for patients and working with nurses.

The film’s realistic portrayal of healthcare institutions, their personnel, patients and practices has led to the use of Code Gray by staff in hospitals, nursing homes, professional organizations and conferences to stimulate reflection and discussion among experienced nurses and other health workers.

Healthcare administrators and attorneys have found the film to be an excellent tool for increasing understanding, within their professions, of the problems which nurses and other health workers face every day. Its focus on commonly experienced episodes in patients’ and nurses’ lives – illness, birth, death, and loss of freedom – and the filmmakers’ avoidance of unnecessary medical language, make this a film which is also of enormous interest to lay audiences.

Scheduling

The film is approximately 26-minutes long, and additional time should be allocated for introduction or audience preparation, if desired, and for discussion or other related activities afterwards.

Since the film is divided into four distinct cases, each one focusing on a particular ethical principle (beneficence, autonomy, justice and fidelity) some leaders may wish to stop the program in between, in order to focus class discussion on the issues of that case. The film has been structured to make this possible, if desired. The filmmakers, however, strongly believe that it is preferable for the audience to see Code Gray straight through when first experiencing it. Since the film was conceived and produced as a coherent whole, with each section supporting and shedding additional light on the others, viewers who do not see it in this way will be missing an important part of the intended impact.

An ideal way to combine these approaches would be to schedule a showing of the entire film for one class session. In a later class or classes the separate cases can be shown and discussed in greater detail. Alternatively, students can be told in advance that they will later be asked to focus on one or another of the principles dealt with in the film. Then, after the film screening, the audience can split into groups to discuss the individual cases. Creative discussion leaders will undoubtedly develop other worthwhile approaches to the cases in Code Gray.

Film as a Tool for Discussion

Like many documentary films, Code Gray is designed not to provide answers but to raise questions. By giving viewers a chance to become deeply, though briefly, involved in real situations involving ethical conflict, it tries to provoke them to examine their own reactions and values and to explore these with others in the audience whose attitudes may be different.

Some students and other viewers, accustomed to more “directive” or “authoritative” teaching materials, will be unaccustomed to this approach, and will feel that they are supposed to agree with the views that are expressed in the film. Since the nurses in the film are themselves in conflict, this is obviously impossible. Viewers, instead, should be encouraged to challenge, to disagree, and ultimately to confront their own values and the ethical conflicts they face in their own lives.

While no special preparation is needed to show and discuss this film, it may be helpful to read through this guide in advance. Discussion leaders may also want to acquaint themselves with some of the background materials mentioned in the bibliography.

Some leaders will wish to prepare their audience for the film by discussing, for example, some of the ethical principles dealt with in the four cases. Others prefer to avoid creating any particular expectations or mindsets in their students or audience, wanting them to experience the film more immediately, and to formulate their own responses.
What is Nursing Ethics?

Ethics is the study of moral principles, of right and wrong conduct, of good and evil character, of just and unjust community organizations, of values, virtues and vices, and of moral rights, duties and obligations. Ethics derives from the Greek word *ethikos*, and is defined by the *Oxford English Dictionary* as “the department of study concerned with the principles of human duty.” Morality comes from the Latin word *moralis*. According to the same dictionary, morality pertains to “the distinction between right and wrong, or good and evil, in relation to the actions, volitions or character of responsible beings.”

Although the words “ethical” and “moral” are often used interchangeably, some philosophers tend to reserve “ethics” for referring to the *formal* study or discipline, while using “morals” in the more common fashion to refer descriptively to accepted values and practices.

Ethics is not directly concerned with what the law *is*, or with what policies, customs, or institutions are. Ethics addresses what the law and other rules and practices *ought* to be. Sometimes “ethics” is used to refer to the constellation of values, beliefs, and practices of a particular group (as in *Judeo-Christian ethics*) or person (as in *Nixon’s ethics*). “Ethics” also sometimes refers to a code of professional conduct such as legal or medical ethics.

What, then, is NURSING ETHICS? It is the application of general moral principles to the profession and practice of nursing. Nursing ethics deals with the duties and obligations of nurses to their patients, to other health professionals, to their profession, and to the wider public.

A comprehensive nursing ethic includes considerations not only of moral *conduct* (how should one act), but also of moral *character* (what sort of person ought one to be), and moral *community* (how should society be constructed to enable ethical people to act ethically) which make possible and sustain right moral acts.

As in many of the service professions, nursing’s professional organizations have developed codes of ethics which express their members’ commitments to their patients, to their colleagues, and to society. No set of codified, general statements, however, can thoroughly deal with all the possible moral dilemmas nurses may encounter, or with the complicated nuances of specific cases. Thus nurses must still ponder for themselves what it means to be ethical, and then behave ethically, in their actual, day-to-day practice.

To view the Code of Ethics developed by the American Nurses Association, visit their website at: http://www.nursingworld.org/ethics/ecode.htm

Glossary of Terms Used in the Film

**Cerebral Cortex:** The outer layer of the cerebrum, which is the largest part of the brain, receiving and interpreting sensory input, controlling all voluntary muscular activity and mental faculties such as memory, learning, reasoning, judgment, intelligence and the emotions.

**Code:** If a patient suffers cardiac or respiratory arrest, staff present may “call a code,” summoning emergency personnel and equipment and beginning cardiopulmonary resuscitation. A “no-code” (do not resuscitate) order instructs the staff not to initiate such measures.

**Diabetes Insipidus:** A chronic condition caused by inadequate secretion of an anti-diuretic hormone due to damage to or inadequacy of the pituitary gland, resulting in inability to regulate electrolyte balance.

**Electrolytes:** Substances such as sodium, potassium, etc., which, in solution in body fluids, conduct and are decomposed by electrical currents. Electrolytes in proper balance are essential to human life.

**Hydranencephaly:** Congenital absence of brain tissue, inside a formed skull containing fluid rather than brain tissue.

**Hypotensive:** Denotes low blood pressure which, when very low, indicates that the contraction of the heart muscle is not strong enough (or is undermined by other damage) to keep blood flowing forcefully to all the vessels of the body.

**Transillumination:** Inspection of a body cavity (in T.J.’s case, the cranium or head) by passing a light through its walls.

**Triage:** The categorization of injured and sick individuals according to whether they would live without any treatment, would die in spite of any treatment, or could benefit from treatment, in order to allocate medical and nursing resources efficiently, especially in emergencies.
Some General Discussion Questions

1. Are the situations seen in this film realistic? Are they typical of situations you are familiar with from your own work? In what ways are they similar or different?

2. Are the ethical problems faced by nurses the same as or different from those faced by other professionals such as doctors, social workers, lawyers, teachers? In what ways?

3. Do you feel that the general public are aware of the kinds of issues nurses have to deal with? In what ways are they supportive or not supportive of nurses?

4. Do you think physicians are aware of these issues? In what ways are they supportive or not supportive?

5. Would you agree that there has been an increased concern with ethical dilemmas in nursing in recent years? If so, why do you think this is?

6. Do you feel the nursing hierarchy in your institution are supportive of staff in dealing with these issues? In what ways? What about the nurses’ union, if there is one? What about your professional organizations?

7. In what ways might the structure of your institution be improved, either to reduce the incidence of ethical dilemmas or to provide greater support to nurses in dealing with them?

8. Generally speaking, in what ways do the social structures of hospitals, nursing homes and other healthcare institutions either contribute to or alleviate the ethical problems nurses face?

9. What effect do job description, supervision, institutional rules and policies have on your decision making?

10. Do you feel nurses are sufficiently trained to prepare them to confront such dilemmas? In nursing school? In staff development or continuing education programs? In what ways could training be improved? What kind of knowledge and skills would be helpful?

11. What resources or tools are available in your organization or institution which can help nurses in dealing with these dilemmas? Are there ethics consults? Ethics rounds? How would you evaluate the adequacy of these resources?

12. Discuss whether any of the following mechanisms or tools are available to nurses in your institution or in your community? How effective do you think they are?
   - Informal discussion among nurses, staff;
   - Access to the formal authority structure, for example, the nursing supervisor;
   - Nursing ethics rounds, or discussion of ethical issues during nursing care conferences;
   - Interdisciplinary ethics rounds;
   - Representation of nurses on such bodies as hospital ethics and human subjects committees, institutional review boards, or infant care review committees;
   - State boards of registration for nursing;
   - Ethics commissions or committees of state nursing organizations;
   - Nursing unions dealing with ethical concerns through contract terms or grievance procedures.

13. As several people note in the film, “Even when you make the right decision on an issue, you might still face tragedy and loss, and guilt.” In what ways does an understanding of ethics help to deal with such feelings? What other factors or circumstances make it easier or harder to deal with such feelings?
In Case 1, the nurses caring for a newborn with severe birth defects must decide what kind of nursing care constitutes doing good for their patient, and what may constitute doing harm. There are differences of opinion among the staff, particularly between the Primary Nurse and one of the Associate Nurses, about how aggressively to attempt to feed the baby, T.J., and about the appropriateness of trying to wean her from the isolette.

Description of the Case

T.J. was born at term to a young mother in her 20’s, following a normal pregnancy and routine prenatal care. Her mother had decided early in the pregnancy that she would give her child up for adoption after birth. When T.J. was born, physical examination and transillumination revealed a slightly enlarged head and hydranencephaly, which a C-T scan later confirmed, revealing the absence of cerebral cortex tissue. As a result, she developed diabetes insipidus, and could not internally balance her electrolytes and body fluids. She lacked the self-regulatory mechanisms for temperature control, and she did not see or hear. Yet at birth she was an attractive and well-nourished, though lethargic, newborn, whose severe “defects” were not immediately visible. She did not receive a name from the state Social Services office for several weeks, and was named by the nursing staff in the interim.

No medical or surgical intervention could correct or adequately compensate for T.J.’s lack of upper brain cells. She was only expected to live a matter of weeks or months (although a few hydranencephalic children do live for several years, with very aggressive early care and constant, skilled vigilance.) The state relied upon the judgment of T.J.’s caregivers to provide good nursing and medical care and to act in her best interest. She was seen daily by excellent physicians, who followed her course carefully. T.J. was cared for continually by nurses. Her Primary Nurse, Janet, was responsible for coordinating T.J.’s care, writing and updating the Nursing Care Plan, and meeting regularly with the Associate Nurses, including Jeanne, who also cared for T.J. regularly.

Shortly after birth, it became clear that T.J. frequently could not retain and often did not digest her formula. She vomited after every feeding. When nurses would insert a tube through T.J.’s nose into her stomach, they could more carefully regulate and slow her intake, eliminate swallowed air, and sometimes prevent or at least decrease the amount of her vomiting. However, this was one of the few events which aroused and provoked T.J., leading to her unusual, high-pitched cry.

Although normally lethargic, hypotonic and difficult to stimulate, T.J. also cried following the drawing of blood for lab tests which would indicate her electrolyte status. Nurses also noted that T.J.’s temperature would drop dramatically when she was removed from the temperature-controlled isolette.

T.J.’s biological mother did not visit, and an adoptive or foster home was not available. Her hospital bills were being paid through state funds.

The Principle: Beneficence

The principle of beneficence encompasses the ethical precepts that we ought to do good and to prevent or avoid doing harm. Some moral philosophers distinguish duties of beneficence, which rest on the fact that we can improve the condition of others in the world, from duties of non-maleficence (of not injuring or harming others) which is considered by many to be a more binding duty. This sense of stringency is borne out by the centuries-old maxim of medical ethics, primum non nocere (above all, do no harm.) At the same time, examination of codes of medical and nursing ethics reveal unusual emphasis upon the duty to do good.

The special training of healthcare workers – their ability to do good – is sometimes seen to impose upon them a responsibility or moral obligation to do good that is greater than that of others. Since harm and good seem so often linked in healthcare (as when Janet believes that prolonging T.J.’s life is a good thing to do and Jeanne considers it harmful), it is useful to discuss both avoiding harm and doing good as duties of beneficence, while remaining aware of the particularly compelling quality of the obligation to avoid harm.

Thus the principle of beneficence may be said to include the injunctions to avoid causing or inflicting harm, to prevent harm, to do good, and to promote good. However, as T.J.’s nurses are discovering, even when we desire to be beneficent, it may be extremely difficult, in practice, to determine what distinguishes harm from good.
Notes on Case One

4. Frankena, page 47.

Questions for Discussion

1. As you view the case shown in the film, what level of nursing care do you consider to be beneficial or harmful to T.J.?
   - Is nasogastric feeding beneficial or harmful to T.J.?
   - Would not feeding her anything be more or less harmful?
   - Which is the greater harm: Death or a painful life? (and how do we decide how painful life must be before we may consider maintaining life to be harmful?)

2. In T.J.’s case, how would you resolve the dilemma between short term quality of life (holding, comforting, not forcing feedings) versus prolongation of life (feeding, possible surgical intervention, etc.)? Can you relate this dilemma to situations you have encountered in your own practice?

3. Some comforting measures the nurses would like to take with T.J., such as holding her, involve increased risk. Would you feel such risks were justified in this case?

4. What kinds of clinical and moral decisions should or must nurses make in order to care for T.J.? In what way are nursing decisions different from medical (physicians’) decision making?

5. Some people feel that only physicians should be making the kinds of decisions we see the nurses making in this case. How do you feel about this? Who else, besides nurses and physicians, should be involved in such decisions?

6. If the attending physician ordered all feeding stopped, how would that affect Janet’s ethical position? Jeanne’s?

7. In the event of a respiratory or cardiac arrest, should nurses call a “code,” and participate in full cardiopulmonary resuscitation of T.J.? What would you do in a situation where:
   - The physicians have ordered a full code but nurses disagree,
   - physicians have given a “no-code” (do not resuscitate) order but the nurses disagree,
   - The healthcare team agrees the patient should not be resuscitated but no order has been written to that effect.

8. In addition to your own feelings and ethical values, what legal and political factors would you have to take into account in deciding what to do in the above situations?

9. The other nurses involved in T.J.’s care may defer to Janet’s opinion because she is the Primary Nurse, even though they may disagree with her. Is this acceptable ethically? What if one of the others strongly believes the Primary Nurse’s decision is wrong? How would you deal with such a situation?

10. It might sometimes occur that a patient receives inconsistent care from several different nurses. Would this make the ethical dilemmas of the nurses easier or more difficult to resolve? Would it be better or worse for the patient?

11. During Interdisciplinary Ethics Rounds, Janet asks “Should you push the feedings on the baby even though they’re probably not doing any good just because it makes you feel you’re giving the baby some nutrition?” Is this a morally acceptable reason for feeding T.J.? What weight should we give to the nurse’s conscience and her long-term ability to care compassionately for such children?

12. Does it make a difference that T.J.’s natural parents do not participate in making decisions about her care? If so, how, and in what ways?

13. If parents were involved in T.J.’s case, would that let the physicians and nurses off the hook? Would it be OK ethically to leave the decisions about feeding or not feeding entirely up to the parents? As the nurse in this case, what would you do if:
   - the parents wanted feeding withdrawn but you disagree,
   - the parents insisted that aggressive feeding be continued when you considered it harmful.

14. What legal or institutional considerations (for example, hospital policies, governmental reporting regulations, problems of liability and malpractice, etc.) would you think about in deciding what to do in the situations described above?

15. If T.J. survives, she will require extensive and costly long-term care. What types of facilities, if any, would be available to care for her in your community? Are they adequate, in number and in quality, for the need? If not, why not?

16. Who should bear the cost of such long-term care? To what extent should this be a factor in determining her care?
The nursing home staff in Case 2 must make a variety of decisions regarding the use of restraints to prevent their patients from injuring themselves or from interfering with other residents. They must weigh their responsibility to protect their patients, against their duty to respect the patients’ right to make their own decisions.

Description of the Case

Olive is 88 years old, alert but forgetful, and unsteady on her feet. She has fallen in the past, and the nurses have become increasingly concerned that she may injure herself so seriously (breaking her hip, for example) that she might never walk again. The nurses’ requests that Olive call them to walk with her have not been successful. Now they suggest that Olive wear a belt tied around her waist and around her chair in order to remind her not to get up without someone to walk with her – and to prevent her from getting up unaided. Olive objects. She is unwilling to give up her ability to move about the home as she chooses. Though her nurse, Sharon, persuades her to accept the belt on a trial basis, Olive is clearly unhappy.

In another scene, the staff are discussing a different resident, Helene, who is able to walk well, but is quite confused. Helene has been admitted at the request of her family, who live several hundred miles away, and whose efforts to have Helene live with them failed when she wandered away from their home several times.

Helene has been living alone. Because of her increasing senility and her physical needs, the city Social Services can no longer adequately support her at home. She arrives at the nursing home malnourished, poorly clothed and unwashed. The home has agreed to accept Helene on a trial basis but, despite her confusion, she is clearly unhappy there, and she objects loudly to the mechanical restraints which would keep her from wandering off the grounds and getting hurt or lost. She has also created a serious disturbance for the other patients, because of her screaming and wandering into their rooms. Thus she must be constantly attended by nurses or aides.

The nurses wonder whether they should try chemical restraints (medication) which might calm her down and make it possible for her to stay. They are concerned about her safety if she returns to living alone, or if she is admitted to a state mental health facility. The nurses in Olive’s case confront one of the most difficult ethical dilemmas arising from the conflict between the duties of beneficence and respect for autonomy: when a patient’s knowledgeable free choice seems to put her safety, perhaps even her life, in jeopardy.

The Principle: Autonomy

In bioethics, the concept of a person as an autonomous individual leads to the duty of nurses and other health professionals to respect the values and choices of their patients. Although the emphasis upon autonomy is recent, especially in the ethics of healthcare, the roots of this focus upon individuals’ free choice goes at least as far back as Immanuel Kant.1

The principle of autonomy has achieved special prominence in healthcare in part because of a long tradition of emphasis upon beneficence.2 When beneficence is interpreted to mean doing what (the caregiver believes) is good for a patient, there is a tendency toward “paternalism,” where presumably beneficent acts override or lead to a disregard for a patient’s own determination of what is best. The nurses in Olive’s case confront one of the most difficult ethical dilemmas arising from the conflict between the duties of beneficence and respect for autonomy: when a patient’s knowledgeable free choice seems to put her safety, perhaps even her life, in jeopardy.

The present principle of autonomy may be generally expressed as the duty to show due respect for persons. For example, Beauchamp suggests that an autonomous person “should be free to perform whatever action he or she wishes (presumably even if it involves considerable risk....and even if others consider the action to be foolish,)” so long as the actions “do not infringe on the autonomous actions of others.”3

Even if we accept the above statement, are there situations in which a nurse can or should conclude that a patient’s decisions are not truly autonomous or should not, in a specific case, be respected? Philosophers have outlined a number of interrelated factors in our understanding of autonomy.4 Among those which are most clearly evident in Code Gray’s nursing home cases are autonomy as free action (the ability to act upon one’s decisions) and as effective deliberation (the ability to decide rationally, rather than impulsively or, in the extreme case, insanely.)
In Olive’s case, most viewers agree that, although sometimes forgetful, she seems capable of making a rational decision that she wants to be able to move around freely. However, at least in her nurses’ opinions, she is not capable of doing so safely. We might say that she is capable of effective deliberation, but not of free action. Because of her dependence on the staff to care for her, they are placed in the position of having to balance these factors in deciding where their duty lies.

Helene, on the other hand, is physically perfectly able to get around, and even to leave the facility. However, there is very strong evidence that she is not rational. (One of the most frequent complaints that staff have about dealing with patients like Helene is that “We can’t reason with her.”) Helene is capable of free action, but not of effective deliberation. As in Olive’s case, Helene’s nurses must decide to what extent to consider her autonomous and to respect her right to decide.

In deciding whether to use chemical rather than physical restraints, moreover, they also question whether the use of drugs may be a more serious invasion of a person’s autonomy, since they may cause personality changes.

Respect for autonomy may sometimes conflict with the principle of justice (page 11) since autonomy itself must be allocated fairly. If Helene’s desire to be unrestrained conflicts with other patients’ desire for privacy, staff must decide whose autonomy will be respected.

Notes on Case Two
2. Veatch, op cit.

Questions for Discussion
1. How would you deal with the situation Sharon confronts? Do you feel it is right to restrain Olive under these circumstances? If Olive were to fall when unrestrained, would you consider the nursing staff responsible?
2. What if Olive absolutely refused to allow restraints, instead of reluctantly agreeing as in the film? Should the nurse insist?
3. Do people have a right to determine their own behavior, even if it may result in harm to them? What about behaviors like the use of alcohol and tobacco? What about suicide?
4. Are there any other ways to deal with Olive’s situation besides physical restraint? What about round-the-clock care: would that be better or worse for the patient? Would it increase her autonomy or merely decrease her privacy? Is such care realistically possible?
5. Suppose the institution where you worked had a policy stating that any patient who had fallen more than once should be restrained: Would you agree with such a policy? If not, would you follow it nonetheless? Do you feel the existence of such a policy relieves the staff of their duty to decide in such cases?
6. In the second part of this case, nurses must consider the use of chemical restraints, which may cause personality changes and other side effects. Do you think this is justified? In what kinds of cases do you think it is or is not justified?
7. What if a patient doesn’t want to be in a nursing home at all? Under what circumstances are we justified in overriding a person’s own wishes about such issues, and who should be involved in making the decision: the family, physicians, nurses, the courts?
8. In Helene’s case, a balance must be drawn between her rights and those of the other patients she is disturbing: can you think of other situations where one person’s rights must be weighed against those of another?
9. It could be argued that any behavior which interferes with the efficient operation of the healthcare institution thereby conflicts with the rights of other patients. Do you agree with this? Under what circumstances would you agree or not agree?
10. Would the use of behavioral modification programs for either Olive or Helene be a morally better solution? Why or why not, and under what conditions?
11. What institutional factors influence the use or non-use of restraints in hospitals and nursing homes?
12. If more funding were available to support nursing home care in America, are there ways it could be used to make the use of restraints less necessary? How?
In Case 3, the staff of a small, busy Intensive Care Unit (ICU) are confronted on almost an hourly basis with decisions about the allocation of their care and facilities among patients whose conditions and needs vary. Frequently they may not be conscious of these as ethical decisions, yet in making them each staff member is applying conscious or unconscious feelings, beliefs, attitudes and other criteria which have a moral dimension.

**The Principle: Justice**

The principle of justice, in its most basic sense, requires that we treat others fairly. When there are things to distribute, we should allocate them in such a way that equal shares go to equal recipients. The first paragraph of the ANA Code for Nurses underlines the basic requirement of equality by requiring the nurse to provide care “Unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.” Two practical problems complicate the application of this rule of distributive justice:

- Not everyone is equal in all ways. Sometimes differences among persons lead us to believe one individual should receive a greater or lesser share than another.
- Resources are limited. There often is not enough for each person to receive an equal share.

Frances and her staff are confronted every day by the second of these problems: There simply are not enough ICU beds and equipment – or enough nursing staff time – to meet the needs of all the patients who may need such care. Thus the nurses, whose close involvement with their patients gives them an enormous amount of information, must turn to the first point – what are the relevant differences among patients – for guidance in allocating their resources.

Some patients simply need more of the nurses’ skilled attention than others. They may be more dangerously ill, for example, and require immediate intervention in order to avoid irreparable damage or death. Other patients may...
be able to wait without risk, and still others will probably
die despite any help. The criterion of need, augmented by
an assessment of ability to benefit (prognosis), is basic to
the practice of triage, which is used in distributing nursing
and medical resources whenever they are in short supply.

In addition to the cases of urgent need covered by the
practice of triage are those less immediate and more long-
term needs created by various handicaps resulting from
inherent inequities of nature, accident and fate. Justice
may mean giving unequal – extra – attention to people
with disabilities because only with an extra share of
healthcare resources will they have an equal chance to
achieve the best lives of which they are capable.2

It may also be suggested that some patients deserve
nurses’ care more than others – perhaps because they
have been more compliant or cooperative in efforts to
improve their health, for example by following advice to
exercise, follow a special diet, stop smoking, take medica-
tions, etc.

Sometimes it is pointed out that certain patients areentitled to special care. For example, veterans receive a
portion of U.S. healthcare resources (through the Veterans
Administration hospitals) because of their previous contri-
bution to the common good. Patients who have been
injured by medical or nursing error may also receive
special consideration in an effort to repair the harm done.

In considering qualities that differentiate one
individual from another, it is important to distinguish
between those qualities which are morally relevant (e.g.,
need or prognosis) and those which clearly are not (such
as sex or race.) In ethical analysis and discourse, unequal
treatment always requires justification.

An approach to such justification is provide by
Rawls who suggests that just principles for allocation are
arrived at by individuals choosing from behind a “veil of
ignorance” – not knowing how they themselves would
stand according to the criterion chosen. For example, if
nurses and patients, not knowing how their own prog-
nosis compared with that of others, would still agree
that prognosis is a appropriate criterion for allocation of
resources, then prognosis can be considered a just basis
for such decisions.

A final problem in interpreting and applying the
duties derived from the principle of Justice arises from the
conflict between the requirements of justice and the duties
of fidelity (see page 14). Although fairness is usually com-
patible with faithfulness, it is possible for one’s promises
to a particular person to generate a strongly felt duty to
fulfill those promises, while to do so would demonstrate a
partiality which gives to one person more than is given to
others. Many nurses state that their first responsibility is
to the patients already in their unit (they have made an
implied promise of continuing care), yet this may conflict
with the principle of fairness in a case where a perhaps
more needy patient (or one with a better prognosis) is
awaiting admission.

**Notes on Case Three**

1. The following remarks deal almost exclusively with distributive justice
and do not touch upon retributive justice, which deals with punishment,
nor upon compensatory justice, which deals with restitution, except
insofar as a caregiver may consider the moral claims for special care of
patients who were harmed by a caregiver’s error.
2. For more detailed reasoning on this point see Frankena, op cit, page 51.
Questions for Discussion

1. Do you think the situation seen in this ICU is realistic? Do such problems arise in other, non-ICU settings such as general wards, nursing homes, clinics, emergency rooms, mental health facilities, public health agencies, etc.?

2. To what extent do you think nurses are really involved in making such decisions where you work? To what extent should they be? Who else should be involved: families? physicians? administrators?

3. When you have had to deal with such situations, what factors affected your decisions?

4. If you could establish a formal decision-making system for such situations, what would it involve?

5. Suppose it were possible to operate on a simple principle of “first come, first served.” Would that be acceptable to you ethically?

6. The following are some criteria that are frequently used or referred to in making decisions about allocations of resources, including nursing care, equipment and beds. Rank them in the order of their importance to you if you were making such a decision:
   
   ___ Social Status or Prestige,
   ___ Need (which patient needs care the most?),
   ___ Social Contribution (which patient has done, or will do, the most for society or humankind?),
   ___ Age,
   ___ Prognosis (which patient will benefit most from the care given?),
   ___ Physical Appearance, Personality,
   ___ Deserts (which patient deserves care the most?),
   ___ Ability to Pay (which patients are wealthy or have insurance coverage; which patients’ care will result in financial loss to the hospital?),
   ___ Entitlement (which patient is most entitled to care?),
   ___ Other: ____________________________.

7. Now go back and rank the same criteria in the order of importance that you think they are usually given in making such decisions.

8. Issues of degree also affect these criteria. For example, if you consider age to be a valid criterion, would an age difference of one year affect your decision as to which patient should be assigned an ICU bed? Five years? Twenty years?

9. Do you think issues of ability to pay affect these decisions at the unit level? What about in determining which patients will be admitted to the hospital in the first place? What do you think about this?

10. Have you ever experienced a situation where a famous or “important” person was a patient in your institution? Do you think that they received the same care as any other patient? If not, how was this justified or explained? How do you feel about this?

11. Suppose you were confronted with the following group of patients awaiting admission to your ICU, which has a limited number of beds. Their medical conditions are similar. List the order in which you would assign them to the available beds: (You can give the same priority number to more than one patient.)
   
   ___ a 38-year-old police officer,
   ___ a severely retarded 5-year-old,
   ___ an indigent chronic alcoholic,
   ___ an accused rapist,
   ___ Your state Senator,
   ___ the husband of a nurse on another unit,
   ___ an attempted suicide,
   ___ an 85-year-old woman with other severe health problems,
   ___ an infant ward of the state,
   ___ a beautiful and famous actress.

12. Go back and rank the same patients in the order in which you think they would usually be admitted.

13. One way of treating all patients equally is to use a procedure of random selection, thereby making no distinctions among patients. Would you favor this method? Why or why not?

14. In your experience, is short staffing a significant or frequent problem? What ethical factors are involved in a hospital’s decisions about how many nurses to hire or to assign to a particular unit? How might the principle of justice be applied in such decision making at the institutional level?

15. Why is it that there are not enough resources to go around? What economic and social or political factors are involved in determining the availability of healthcare resources?
In Case 4, which also takes place in the Intensive Care Unit, a nurse confronts the dilemma created when the promises made to different people conflict. Though she wishes to be faithful to her commitments, Mary finds that a promise made by the health team to the family – to continue treatment – makes it impossible for her to carry out what she considers to be her obligation to relieve her patient’s pain.

Description of the Case

Mary is the nurse taking care of Mrs. Carter, who has been in the Intensive Care Unit for many weeks, and who is dying. Mrs. Carter has Lupus Erythematosus, a chronic and usually fatal disease which has spread throughout her system. She has been on a respirator for weeks and appears to be unconscious, though sometimes she is restless, pulls at the tubes in her mouth and arms, rolls her eyes and mumbles incoherently. She does not speak any English, and even with her family or a hospital interpreter, it has not been possible to communicate effectively with her. Her disease, particularly in its final stages, is generally accompanied by pain, and Mrs. Carter does often appear to be in pain. She has not left any instructions about her wishes in the event of incapacitating illness (such as a so-called “living will”) and none of her family recall her ever talking about being sick and incapacitated or dying.

At 57 years of age, Mrs. Carter is the matriarch of a close, large, and very concerned family who are still shocked by her illness and the grim prognosis. Although the physicians and nurses have told the family that Mrs. Carter cannot be cured or helped, and that she will die very soon, the family have begged the healthcare team to try a non-standard treatment which they have heard about. The team have promised to try this treatment for ten days. Even though they do not believe it will improve Mrs. Carter’s condition, they reason that it probably will not hurt her, that they have nothing else to offer, and that at the very least it may help the family by assuring them that every possible therapy was tried in order to save their loved one.

Mary has taken care of Mrs. Carter during much of her hospitalization, and feels very close to her. She is very concerned about Mrs. Carter’s apparent suffering, and would like to give her medication to relieve the pain.

Mrs. Carter’s pain is such that it would not be alleviated by anything less than a narcotic analgesic, and there is a Doctor’s Order for a narcotic pain medication to be administered as necessary. Such drugs, however, have the side effect of lowering vital signs as they produce relaxation. Since Mrs. Carter’s blood pressure is already very precarious, and is being chemically maintained and controlled in order to keep her alive, Mary is afraid that if she gives her any medication for pain it would precipitate or hasten her death.

Aware of the family’s grief, Mary wants to honor the team’s promise to try the ten-day treatment they have asked for. Yet she is torn by her patient’s suffering and by her own inability to fulfill her general commitment, as a nurse, to comfort and relieve such suffering.

The Principle: Fidelity

The duty of fidelity, or faithfulness, includes obligations to be truthful and to keep promises. Fidelity is based in relationships and upon assurances which continue over time. It commits one to a reliability or constancy which is the formal fulfillment of faithfulness, that is, perseverance in one’s promises. More importantly, fidelity retains a certain presence, a quality of “being there” for someone – of making a patient, for example, feel the nurse is with her and for her.

The words, “I promise,” establish a moral relationship which signifies that one has accepted a self-imposed obligation which the other has a right to have fulfilled. In many ways, truth telling and promise keeping are the cornerstones of trust.

The bond between nurses and patients is not simply legal and institutional; it is also personal and moral, composed of less explicit expectations and obligations. For example, patients expect that nurses will not gossip or take advantage of their private personal revelations within the nurse-patient relationship. Reciprocally, nurses expect patients to tell the truth, and to carry out the nurses’ directions.

Some of the nurse’s promises are implicit in her professional role. She is assumed to have “agreed” to those
responsibilities that are generally expected of nurses. Some of these commitments may also be explicit – for example, if a member of the American Nurses’ Association, the nurse may be assumed to subscribe to the ANA’s Code for Nurses.

In the film, Mrs. Carter’s nurse, Mary, believes that patients expect they will receive medication to relieve pain. Moreover, she believes this is a generally justifiable expectation – that she has made an implicit promise, as a nurse, to do her best to alleviate suffering. Her feelings of responsibility may be intensified because she feels that her actions during the long hospitalization have encouraged Mrs. Carter to trust her to provide comfort.

Yet this tacit commitment must be weighed against the more specific, explicit promise made by the healthcare team – of which Mary is a part – to try a special therapy for ten days. Since Mrs. Carter’s cardiovascular status is so unstable, it is not possible simultaneously to keep her alive in order to administer the requested therapy while also giving pain medication. The two promises by which Mary feels morally bound cannot both be fulfilled.

Many different people have expectations of nurses. Patients, for example, can properly expect that they have a right to the nurse’s time, skill and care. Physicians believe the nurse has promised to aid and assist them in healing the patient. And the hospital believes the nurse has promised to follow their rules and reasonable requests (such as “floating,” or temporarily transferring to another unit.) The family may expect that the nurse will fulfill their requests on behalf of their loved one. In addition, there is the ever-present but rarely addressed difficulty of the nurse being true to herself.

When nurses’ promises to different persons cannot all be fulfilled, an ethical dilemma exists, and a moral choice must be made.

Notes for Case Four


Questions for Discussion

1. What factors must Mary weigh in deciding which of her promises should take priority? What aspects of the case could change that might lead her to change her priorities?

2. “We know that her situation is irreversible,” Mary says. Can we ever really know something like this for sure? What degree of knowing: is necessary for us to make ethically grounded decisions? To what extent, if at all, should we be influenced by our patients – or our own – hope for “miracles” (medical or otherwise?)

3. Suppose Mrs. Carter were able to communicate, and expressed the wish to be allowed to die – would that be sufficient to resolve the dilemma? What if, in such a case, the nurses believe there is still hope that the illness can be cured and the pain relieved?

4. How does one determine when a patient is competent to express his or her wishes? What if that expression is by “signals” rather than by a clear verbal statement? Some of the nurses, for example, felt that Mrs. Carter’s tugging at her respirator tubes indicated her wish to be allowed to die? Do you agree? Are there ways you could try to determine the wishes of a patient in this situation?

5. The staff do not believe the treatment requested by Mrs. Carter’s family can do her any good. Does their keeping her in the ICU for 10 days conflict with the justice principle, since other patients may need the bed she is occupying? Obviously she needs the ICU’s facilities to survive, yet in terms of prognosis, she cannot benefit from this care?

6. In this case the commitment of the family was made by the entire healthcare team, of which Mary is a part. How would it affect things if the decision had been made by the physician alone and the nurse involved disagreed? Should she speak out and try to convince the others involved? Should she act on her own beliefs, even if it means going against Doctor’s Orders? Should she withdraw from the case? What would you do in this situation?

7. If Mrs. Carter were your patient, and you were alone with her when she went into cardiac arrest, what would you do?

8. Some staff might argue that their first responsibility is to the patients already in their unit. One argument for this point of view is based on fidelity: We have made commitments or promises to our patients which must be kept. But isn’t there also an implied promise to the community at large that health workers will provide care to all equally? How can we balance such conflicting commitments?

9. What kinds of supports do you think should be available to help nurses in situations like Mary’s – both in making ethical decisions and in dealing with the consequences of those decisions? What supports are available in institutions you work or have worked in?
By Susan Reverby, PhD

Historians tend to ask very different questions about ethics than do philosophers or ethicists. Because we are concerned with people’s consciousness and behaviors, we want to know what people do in given situations and why they do it. We are less concerned with elucidating the principles of what ought to be done than in trying to understand the values which influence people’s behaviors and the material contexts which constrain those behaviors.1

Since the introduction of training in the 1870’s, in nursing, unlike medicine, the question of ethics and practice has never been a separate one? As Anne Goodrich, Dean of Yale’s Nursing School, wrote in 1923, “so much is nursing of the essence of ethics that it is consistent to assert that the terms good and ethical as applied to nursing practice are synonymous.”2

Critics of nursing have charged that, because of this dictum, training in nursing began as the development of “character, not skill.”3 But it is crucial to understand that, for the leaders of 19th century nursing, character was the nurse’s skill. Reflecting upon this, physician John Shaw Billings rather off-handedly told nursing leader Lavinia Dock that nursing did not need a code of ethics, for all that was necessary was for the nurse to be a good woman.4 Practicing nurses and nursing educators tried to breathe life into this concept, realizing more, I suspect, than did Billings, that training was necessary to become a good woman as well as a good nurse.

By the turn of the century, however, nursing found itself less and less able to control what defined either a good nurse or her training. In hopes of bringing some clarity to the issue and providing guidelines for training and practice, Isabel Hampton Robb wrote one of nursing’s first ethics books. “The rules of conduct,” she noted, “adapted to many diverse circumstances attending the nursing of the sick, constitute nursing ethics.”5 While Robb carefully delineated between ethics, as having moral weight, and etiquette, as conventional forms of conduct, it is clear in her text that the two became merged.

Looking back on Robb’s book, and the numerous others that followed, it is clear the nursing leaders of her day thought about ethics somewhat differently than we do now. They saw ethics in nursing as the morals of etiquette, the rules of personal and professional conduct toward patient, family, physician and healthcare institution.

In our 1980’s wisdom, we may find it slightly humorous that nurses and physicians were then so very certain that the following of set rules of conduct would ensure ethical behavior. We know from long and bitter historical experience the dangers of applying strict rules of conduct, or assuming one set of principles can govern behavior at all times. Rigidity, and the martinet adherence to rules, became the hallmark of the turn-of-the-century trained nurse, a legacy nursing has struggled to shed throughout the 20th century. However, in linking ethics to etiquette and the relationships between the nurse, the physician, the patient and the healthcare setting, these early nursing ethicists do have something to tell us. However negatively we may now view the ethics of obligations and behaviors that they stressed, they understood that ethics had something to do with both power and social setting. Without using words such as power or social context, these nursing ethicists clearly believed that proper and ethical behavior was constrained by the social situation the nurse found herself in and was related to the power the nurse had, or did not have, in relationships to physicians, institutions and patients.

By the ethics books of the 1920’s, nursing appeared to be moving away from such a stress upon right living and behavior (although the books through the 1940’s and 50’s did discuss such ethical dilemmas as whether the nurse could marry and still work.)

Instead, as in medicine, ethics in nursing was discussed in terms of effectiveness.6 As science became increasingly important, nursing ethics was seen as doing the right things in practice so that the ethical outcome would be the most effective one possible for the patient. Anne Goodrich reminded her readers in the mid-1920’s that ethics are more than rules of conduct, acceptance of hierarchy and etiquette. Ethical concepts could only be developed, she believed, “through adherence to the tenets of that exacting master, science; science that uncompro-misingly seeks, achieves and discards.”7 In our own age of increased skepticism about science’s ability to produce
such clarity, this rule for ethics seems too limited as well. But it adds the perspective that ethics must have something to do with the nurse’s ability to be effective.

Having been somewhat abstract here, I want to bring all these thoughts together to focus on some questions about the film, Code Gray. I have been arguing that the history of nursing ethics has to be thought about not just as rules of etiquette, or even our modern equivalent in principles of moral conduct, but in terms of the elements of social context, effectiveness and power relationships. It is not enough to discuss nursing’s ethical dilemmas abstracted from the social situations in which these dilemmas arise. We cannot just ask how do we decide who to save, unless we also ask why do we have to decide who to save, and can we implement our decisions once they are made. A film on nursing ethics has the moral obligation, as it were, to ask how we decide what baby to save and when, but also, do we have the power to enforce this decision once it is made, and why aren’t there decent institutions where this child can be given a reasonable life if we do decide to save her. The ethical questions to focus upon become not only how we make effective choices with limited resources, but also why these resources have become limited in the first place, and why we accept these limitations.

We are in danger of becoming as antiquated and rigid in our thinking about ethics as we may now perceive those who saw nursing ethics as easily defined right behaviors. We cannot elucidate a set of principles without discussing the values, behaviors, and power that condition our acting upon those principles in specific settings.

Nursing educator and ethicist Mila Aroskar asked in 1977, “Can nurses be ethical in the healthcare structure as it presently exists.” I ask you to ponder these questions as we discuss the dilemmas this film has raised and the structures for answering these questions that history provides for us.

Ethics is not just a question of competing rights and rules. It is a question embedded in the very nature of social life – with competing obligations, power, and resources. No study, or film, or discussion of ethics can, or perhaps ought, to be complete without acceptance of this level of questioning. Nursing educator Claire Fagin once suggested that “the nurse should have the right not to do” when she deemed it necessary. I would like to leave you with the thought that we consider under what circumstances and how nurses obtain such a right.

Notes for “An Historical Perspective”

1. Ilan M. Brandt, “History and Ethical Dilemma,” Harvard University Medical School, Department of Social Medicine and Health Policy (unpublished paper).
5. Nursing Ethics. J.B. Savage, Cleveland, 1901, page 15.
Heartbeat sound…music…

VOICE 1 (JANE): To me, one of the most difficult things that nurses have to deal with is ethical dilemmas. Once they’ve been here six months to a year and they’ve got the technology down pat, then you really get stuck with the why, and the what am I doing to this person, and what is this person experiencing? And you’ve got to be able to cope with that and live with that in order to stay at the bedside.

VOICE 2 (SHARON): There’s so many pros and cons… and even though you make a decision, it isn’t necessarily the right one…

VOICE 3 (FRANCES): I may be wrong sometimes in going ahead and giving aggressive therapy to someone and prolonging their life and making them suffer. In that case maybe I am taking the family’s side over the patient’s…

VOICE 4 (MARY): There are a lot of times patients in the ICU that we feel that way about. Then you’re in a real gray area…

ANDY JAMETON, PhD: Even when you make the right decision on an issue you might still face tragedy and loss – and guilt. Nurses see a lot of tragedy and suffering. In some ways I picture the hospital as an institution which kind of draws and concentrates suffering into one place. Nurses, therefore, are specialists in suffering. They kind of sweep it up on the wards, and they come and talk with ethicists and say, “What am I supposed to do with all this suffering?

“I think ethics offers clear thinking about these decisions, some perspective on their nature and their ancient history, some comfort, and clarity about choosing directions in the face of uncertainty.”

CODE GRAY: Ethical Dilemmas in Nursing

With Commentary by Christine Mitchell, RN

FOUR CASES…

Case 1 — Children’s Hospital, Boston

T.J. WAS BORN WITH SEVERE BIRTH DEFECTS. EVEN BEFORE SHE WAS BORN HER MOTHER HAD DECIDED TO GIVE HER UP FOR ADOPTION, AND SO T.J. IS A WARD OF THE STATE.

T.J. IS PROFOUNDLY RETARDED, AND SHE’LL PROBABLY NEVER BE ABLE TO SEE, HEAR, WALK OR TALK. SHE CAN’T SUCK, AND VOMITS BACK HER FEEDINGS, AND THE NURSES HAVE TO DECIDE HOW AGGRESSIVE TO BE IN FEEDING HER. IT’S ALSO VERY RISKY FOR THE NURSES TO EVEN HOLD T.J., BECAUSE WHEN SHE IS TAKEN OUT OF THE ISOLETTE, HER TEMPERATURE DROPS DANGEROUSLY LOW.

JANET: What we’re trying to do now is wean her from the isolette. And we’ve tried to do that several times and it’s just not working. She was out yesterday and her temperature went down this morning...after 24 house it went down to less than 35 rectally. So for her feeds, for you, I’ve put her back to SMA...

CHRISTINE: On the one hand we want to say one thing is in the child’s best interest, that is, perhaps not treating her because of the possible pain or suffering, and on the other hand we’ve got the concern about whether not treating her is wrong, and that’s what there’s some disagreement about.

JANET IS T.J.’S PRIMARY NURSE. JEANNE IS ANOTHER NURSE CARING FOR T.J. THE NURSES INVOLVED IN THIS CASE HAVE TO FIGURE OUT WHAT IT MEANS TO CARE COMPASSIONATELY FOR THIS CHILD – WHAT THEIR OBLIGATION TO DO GOOD FOR HER ACTUALLY ENTAILS IN NURSING PRACTICE.

JANET: As far as I’m concerned it’s feeding. Feeding is really the issue. And keeping her warm. If you don’t do that, then she is going to die, and if she’s going to die anyway then let it be from something else, but not from lack of what I consider to be just basic nursing care.

JEANNE: I feel that to some extent that if she is going to die, we could allow her to die, even if it is by dropping her temp, or by the fact that she’s not tolerating. And if it’s a course that’s naturally going to occur, that she is going to die, then we’re just prolonging that, we’re extending her life.

JEANNE (VOICE-OVER): I guess I’m torn between what...what is causing the most harm, putting the tube down, giving her food and having her vomit, or just not bothering with that whole process to begin with. Putting a tube down your nose is a painful procedure, and it’s, to me, aggressive, and I didn’t want to start doing that with her. And I don’t feel that even if she does live very long the quality of her life is going to be very good. I just feel
we should do comforting sort of actions with her, as far as holding her and trying to feed her, but not doing a lot of aggressive tests with her.

JANET (VOICE-OVER): We don’t know if she’s going to live or not. That’s the whole point. I feel comfortable when I know she’s eating. When I feed her and she doesn’t take it, my instinct is to put a tube down and make sure that she gets it, one way or another. I don’t feel that that’s aggressive, Jeannie does. To me it’s just maintaining her. I just can’t feed her and watch her either vomit it back or not take it and then know that she’s dehydrating. Because I feel that if she’s dehydrating she’s going to die, and that I’m a part of that.

GOSIA (ANOTHER NURSE): I don’t think anyone has problems with the idea that she may or may not die. Nurses deal with dying patients, even little kids, all the time. I mean that’s nothing new to nurses. All we really want to do is not do anything heroic, we’re not talking about codes, we’re not talking about anything that’s dramatic. We’re just talking about let’s try and get her to keep her food down and keep her warm.

TISH (NURSE): I don’t think that we need to put someone through a lot of traumatic experiences if it’s not going to do them any good.

JANET: Well, I don’t feel that I’m aggressive at all, but looking …listening to you, maybe I am.

CHRISTINE: But that’s the nature of a dilemma, to be able to see both sides as justifiable.

JEANNE: But it’s a horrible position to be in, when you are the one that you see three sides, you see that all three would be correct and yet now here you are – you’re the one that has to put things in writing, and it’s your care plan, and you’re the one making recommendations.

CHRISTINE: Is there any possibility that a joint conference would be useful?

Interdisciplinary Ethics Rounds

MEL LEVINE, MD: The nurses that presented this case have brought us some of their own ethical concerns about the case. This child raises issues that make it difficult for us to know what will influence our decisions.

JEANET: Should you push the feedings on the baby even though they’re probably not doing any good just because it makes you feel that you’re giving the baby some nutrition? And if the primary nurse determines that a certain route should be taken, other nurses might feel that it’s an imposition to the baby to feed it or to risk aspiration.

LEVINE: In this case, what you’re saying is should we substitute comfort for whatever longevity this child is going to have? Take more risks with her life than we would with another child’s life in the interests of more comfort in the short run since we don’t have much hope for her in the long run…which is very much a nursing decision-making issue, as opposed to a traditional medical decision-making issue. It’s the here and now, bedside decision-making. It’s ongoing, and it has to be very private. What a doctor writes in the order book is rather exposed, but a nurse alone in a room with a patient has a lot more conscience to contend with.

Case 2 — Eastwood Pines Nursing Home

THE PRINCIPLE OF BENEFICENCE, OR DOING GOOD FOR THE PATIENT, SOMETIMES CONFLICTS WITH THE PRINCIPLE OF AUTONOMY, THAT WE OUGHT TO RESPECT A PATIENT’S FREEDOM TO MAKE DECISIONS.

P-A SYSTEM: …for East Two, Kay Spoffard for East Two…

SHARON: OK, Olive, recently we’ve had some problems with close calls as far as falling goes, cause you’re not as steady on your feet as you used to be?

OLIVE: Remember, I fell…?

SHARON: Yeah, so I think that probably now is the time that we should consider maybe a restraint.

OLIVE: No, I don’t want to be tied down.

SHARON: Well, this isn’t really to tie you down. We’re going to use this as sort of a reminder, so that you don’t get up without ringing your bell so one of the nurses can come walk with you.

OLIVE: You know, I have the feeling that as long as I can do things for myself, I don’t want to be bothering somebody else. I get my exercise by walking down the one corridor and back, and then down the other corridor and back. Upstairs here and then down on the ground floor too.

SHARON: You’ll still be able to do that, Olive, only you’ll have company. OK, Olive, this is the belt that we’re going to use.

OLIVE: I don’t want it.
SHARON: I know you don’t want it, but you realize how important it is. If you should fall you’re going to break something and then it wouldn’t be a matter of when you wanted to get up – you’d probably be in bed, and you don’t want that to happen do you?

OLIVE: No...

SHARON: But you’ll always have your bell cord that you can ring for them.

OLIVE: I’m not going to be restrained...

SHARON HAS TO WEIGH HER OBLIGATION TO RESPECT OLIVE’S FREEDOM, AGAINST HER OBLIGATION TO PROTECT OLIVE.

SHARON: It’s always a hard decision to make, though. We’d rather have everybody just walking around and doing as they saw fit. This is their home, and we’d like to maintain that as long as absolutely possible – that they’d be comfortable here, to be able to come and go outside, visit family, friends, come back, go shopping, that type of thing. And it’s a very difficult decision to make when a patient reaches the point where they just can’t handle it any more, and it is taking away a freedom from them, which nobody really wants to take away.

SHARON: OK, Olive, this is called a posey belt. Now you can wear it underneath your clothes if you’d like.

OLIVE: That’d be a good idea. Then it wouldn’t show.

SHARON: OK, we’ll lift this up. There. See, we’ll put this part in the front so you won’t even know you’ve got it on.

OLIVE: No...except I do.

SHARON: You think you can live with that?

OLIVE: I guess so.

SHARON: We’ll try it?

OLIVE: I’ll try...

SHARON: OK, so I’m going to go now.

OLIVE: Oh, are you going to leave this thing on me?

SHARON: Yes, I’m going to leave it on now for awhile.

ANOTHER PATIENT IN THE NURSING HOME IS PHYSICALLY FIT BUT MENTALLY CONFUSED. THE NURSES HAVE TO DECIDE HOW FAR THEY SHOULD GO IN PROTECTING THIS PATIENT, AND HOW FAR THEY SHOULD GO IN PROTECTING OTHER PATIENTS FROM HER NOISINESS AND HER WANDERING.

Screaming in background...

KAY (HEAD NURSE): I have to make a decision this morning. Either we keep her and she changes her mind and is willing to stay...

SHARON: And I don’t think she’s responsible enough to make that decision by herself.

KAY: …we keep her and medicate her, and probably restrain her at the same time...

SHARON: …take a woman that’s fairly alert and make her...

KAY: … and who is physically in great shape and who can ambulate down the halls without a problem at all.

SHARON: A lot of the nurses are opposed to medicating a person like that, but we probably would have no alternative.

OLDER NURSE: It’s a hard thing. It’s something I do very reluctantly even if the orders are there.

KAY: Physically restraining her doesn’t even seem as bad as the chemical...

OLDER NURSE: … where she doesn’t have the opportunity to fight it off...

KAY: … and it has so many side effects...

SHARON: You can change a person’s whole life – their whole personality.

KAY: But also the physical restraint is not going to keep her quiet, which is a big problem with all the other patients on the floor... so you end up doing both.

SHARON: There’s no happy medium. And she’s frightened, she has nobody to turn to. It places the burden of responsibility directly on the nursing staff.
Case 3 — UCSF Medical Center

THE PRINCIPLE OF JUSTICE HOLDS THAT WE SHOULD TREAT PEOPLE FAIRLY.

COHEN: We’ve now decided to go ahead and deliver the baby and save the mother. That will probably be done within the next hour or two hours, 15 minutes. What’s our bed situation thereafter?

FRANCES: Well, I’ll call the person who’s on call. That’ll leave us two extra beds. If we have a light admission we can probably absorb them. We can’t really accommodate two more people tonight.

ANNE DAVIS, PHD: In a situation, such as an ICU where you have a limited number of beds and you have more patients than you have bed space, nurses are confronted with making a decision as to who gets a bed and who doesn’t, and in that decision they are essentially relying on the principle of justice.

DAVIS: If you have already ten patients, and you’re staffed for ten patients, and you bring in another patient, who is just as sick and perhaps even sicker than some of the ones who have been there for a while… how is that patient going to be accommodated and get the same kind of quality of care…?

FRANCES (on phone): … right now, we do not have a bed….

FRANCES IS THE CHARGE NURSE OF THE INTENSIVE CARE UNIT. SHE AND HER STAFF HAVE TO DECIDE, WITH PHYSICIANS, WHICH PATIENTS WILL BE ADMITTED TO THEIR UNIT, DISCHARGED FROM THEIR UNIT, TRANSFERRED FROM THEIR UNIT… NURSES KNOW AN AWFUL LOT OF THINGS ABOUT THOSE PATIENTS. ALL THE THINGS THAT A NURSE KNOWS ABOUT A PARTICULAR PATIENT CAN, AND PERHAPS INEVITABLY DO, ENTER INTO THE NURSE’S DECISION ABOUT WHETHER OR NOT THAT PATIENT SHOULD STAY IN THE INTENSIVE CARE UNIT, OR WHETHER OR NOT THAT PATIENT SHOULD GET ONE-TO-ONE CARE. SO THE ETHICAL QUESTION IS, HOW DO WE CHOOSE FAIRLY – WHICH OF THOSE FACTORS SHOULD COUNT?

JANE (NURSE): I try to bring in reality. I look at prognoses. And again, that seems to be something that a nurse isn’t supposed to do, but if you’re here long enough, you know. Better to schedule the heart in bed six with a nurse all to herself, because the work you put into that is something that you’re going to see some results from.

DIANE (NURSE): When there’s a bed crunch, when the staffing comes tight and we can’t get any extra nurses in, many times because there are viable patients who need the beds, and someone who is not going to live out of the unit is in the bed right now – many times if there are no critical care beds in the hospital there is more of a push to have those kinds of decisions made.

UNIDENTIFIED VOICES: We’ve never had the President of the United States, granted, but we’ve had like a Congressman’s son… I’m sure it was because of the patient’s status that a lot of the cooperation was engendered at 6 o’clock in the morning…

JOAN (SOCIAL WORKER): The quality of this person’s life is a real important factor…. We have recognized a mind-set, that old people are not as valuable as young people. They’ve lived their… there’s a whole bunch of ways of saying it, but it’s saying, gee, he’s had a good life, why should we put him through all this? You put him through all this for the same reasons you put anybody through all this – just in order to live. And if you’ve got five years to live and that’s what you want, you have a right to that.

FRANCES: We send them out after they’ve had the open heart surgery, they’ve stabilized, but they’re still not strong really. They still need a lot of attention. When there’s a disagreement with the attending service about whether or not the patient goes out, for example, I think the patient should stay and they go out and then that baby, say, has a respiratory arrest in the middle of the night, has to be intubated and brought back up again – I get mad. If the baby isn’t ready to go out in my opinion, I’ll say so and I’ll ask for the baby to stay and someone else can go out, if possible, or if not perhaps they don’t need to do the other surgery that day. You know, that usually isn’t what happens. You know, the nurses don’t have the final decision in that, but if you don’t think a patient’s ready to leave, you’ve got to speak up about it.

JANE (NURSE): Because the technology is here, the question of whether this technology ought to be provided for these patients has frequently in the past not really been addressed. But now, when you’re really talking about scarcity of resources, and when you’re talking about cutting down healthcare costs, and Medicare reimbursements, etc., then you’re really running into an area of scarcity of resources. And then the ethical problem of should we? Which patient should we? is the question that’s going to come up.
Case 4 — UCSF Medical Center

THE PRINCIPLE OF FIDELITY SIMPLY MEANS THAT WE SHOULD BE FAITHFUL TO OUR COMMITMENTS.

MARY: I also called her family and told them that she was more serious and that she’d had some episodes this afternoon and that they might like to come in, and the son said that they were already coming in. Uh, will you be coming soon to write anything, or do you want me to write it as a verbal order?

MRS. CARTER IS SEMI-CONSCIOUS AND ISN’T ABLE TO COMMUNICATE HER OWN WISHES. ALTHOUGH THE WHOLE HEALTHCARE TEAM ARE CONVINCED SHE IS DYING, THEY HAVE PROMISED HER FAMILY THAT THEY WILL TRY A FINAL, 10-DAY EXPERIMENTAL TREATMENT.

MARY: Is there anything you can tell me that will make it more clear?

MARY IS TORN BETWEEN HER PROMISE TO THE FAMILY AND HER COMMITMENT AS A NURSE TO COMFORT HER PATIENT.

MARY: … She spontaneously comes back, but it makes me very nervous…

MARY: We know that her situation is irreversible and that it’s even more certain now, tonight, after what’s been happening that she is really deteriorating and is not going to survive under any circumstances, I’m convinced, and yet I can’t really sedate her at this time because of her instability. If it were decided that we would allow her to die, support would be withdrawn, and essentially that means allowing her to go. Then we could give sedation because keeping her pressure up wouldn’t any longer be an issue. And it’s during that time that it’s real uncomfortable, I guess for everyone. For the nurse especially. And of course the patient. Because, if your patient is suffering or in pain, you want…you don’t want that for them. You don’t want their last moments to be uncomfortable. But until a decision’s been made to let them die, then you are obligated to support them the best you can… to keep their blood pressure up. And if that means withholding sedation, we do that here. I guess that’s commonplace.

MARY: That situation is just typical of what comes up, where you feel like you can’t really comfort, and as a nurse, that’s one of the things that you’re taught you’re going to do for people and that’s one of your roles, is to comfort people. And not only to make them well, but also to try and make it as comfortable for them as possible.

And there are times when you can’t do that and you feel like you’ve betrayed the patient – betrayed their trust perhaps.

MARY (continues): You tell patients preoperatively, “You’ll be given medication for pain.” And they believe you. And it is true, but it’s not really true. You don’t tell the patient what really could happen. Which is that you might become unstable and hypotensive, and we might not be able to give you anything. And you might be in a lot of pain and all I’ll be able to do is talk to you and reassure you verbally. You would never tell somebody that. You know, that … you can’t. There’s a lot … there’s so much that people don’t know.

MARY: But at the same time, we have to honor our commitments to her family, too. I mean it’s their mother and wife that we’re dealing with… The nurse is left holding the bag, so to speak. The nurse is at the bedside, trying to support a patient who we know they’re going to withdraw support on. So that’s troubling. Because I still want and have to do everything possible to support her. I am both obligated to and I want to, because of the family. At this point in time, I just want them to be… the promises that we’ve made to them to be kept.

Concluding images from all locations...

FRANCES: Why don’t I just stop and say, “This is enough”? Then what good would my skills be to these people? Often people leave here saying they got the best care, and we feel glad that we know that they got the best care they could have gotten. And that’s a big reward for me as a nurse. It’s one reason I like to work here, because we can give really good care to our patients. You can’t know that you’re correct all the time making these decisions. At least I can be here doing what I can within the limits of my power, to make their death a little easier or their recovery a little more pleasant and a little speedier.

MARY: I don’t usually have people asking me these questions, while this is all going on. You know, you can’t be constantly examining how do I feel about this, or you would be diverting your attention from the job at hand. Afterwards I might go home and think about it. I dream about things at night. I’m sure this happens to everyone. It comes back to you. You try to put…you try not to take things home with you. It’s considered not healthy to do that a lot. So I try not to do that excessively. But sometimes things come back to me in my dreams.

End
Nursing Ethics


The History of Nursing


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