

Know Well to Do Good

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Health care should be entrusted to professionals who have received well-rounded training in the humanitarian as well as the technical aspects of such care. Training of this sort is essential for effective resolution of ethical conflicts that arise in professional practice. Starting from that premise, this article examines a number of ethical problems commonly encountered by nurses in the course of their daily work.

Today's society is characterized by an emphasis on technology, accelerated change, and dehumanization. This situation makes it especially important that medical attention given to the individual should be strongly predicated upon humanistic training.

This calls for comprehensive instruction, not just accumulating and transmitting a body of information. Furthermore, because it provides the basis for a well-rounded education, humanistic training should be a requirement for all—prospective scientists as well as prospective lawyers—and should underlie the practice of any profession. Any good professional should be, in his or her own way, a humanist. Not in vain has it been said that ours is the time of "humanisms," especially when one recognizes the "greatness and misery of man manifesting, sustaining, and favoring his total dignity."²

Conflict-laden situations arise in the exercise of any profession. Besides extensive training and an understanding of mankind's spiritual and transcendent nature, proper handling of such situations

demand an empathetic vocation to provide service—a predisposition to help one's fellows—arising from a confluence of knowledge, compassion, and activity that may properly be considered an embodiment of the concept of wisdom.

Wisdom of this sort, of the natural order of things, is identified with philosophy, the discipline of order *par excellence*, precisely because philosophy deals with the highest principles underlying reality and—above all—the goals of human life. If we feel disoriented and confused, it is because we lack a universal and profound understanding capable of integrating more specialized sorts of knowledge, a comprehensive and radical understanding that even in the midst of advancing technology will remind us that human dignity does not reside necessarily in this advance, but rather in man himself.

Thus, given the shared dignity inherent in each individual and all mankind, the study of humanity provides the basis for a complete education and understanding of a well-defined set of standards based on fundamental and universal ethical precepts. Such study must be included in both basic programs for health professionals and programs of continuing education in order to train qualified professionals who can shoulder

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²See John Paul II, *Christifideles laici*, Ediciones Paulinas, Bogotá 1988, p. 16.

their career responsibilities and help others in such a way as to preserve and enhance the dignity of those receiving their assistance.

This inherent dignity, a basic human need, calls for us to rethink ends and means—not only in extreme situations but in small daily routine tasks. The service that a nurse provides, at all times and in tending to the smallest details of her work, is simply her response to what our society requires.

On the basis of the foregoing, it appears worthwhile to examine some situations more or less representative of those a nurse encounters daily. These are not limited to extreme situations with obvious ethical connotations, but also include lesser ones that should be assessed the same way—situations that all nurses experience in routine daily contact with their patients.

CASE 1: NURSING ROUTINES

To establish nursing routines, the nurse must consider the following factors:

- The patient: his needs (psychobiological and social as well as spiritual), his problems, and his family, as well as the number of patients to be tended.
- The type of care involved: its nature, amount, complexity, frequency, and scheduling.
- The material resources available.
- The nursing staff: the type and number of staff members providing care and the scheduling of their work times.
- The environment: the care facility's structural features, cleanliness and appearance, and the psychosocial ambience.
- The time-frame: the pace of life in

the facility and the customary schedule of daily activities.

Executing a nursing care plan for a group of patients calls for assessment of the above factors using an organized approach that will ensure safe, efficient, and personalized nursing care. The nurse responsible for doing this faces a dilemma implicit in service standards, because these standards are usually geared to the functioning of the service rather than the patients' needs.

Standards are necessary, of course, but they should be flexible; and the nurse should decide what to do from that standpoint, remembering that the subject entrusted to her care is a human being. This is true despite the fact that it is easier to rigidly follow some standard than to assume a commitment and exercise one's own judgment before the patient, the person responsible for authorizing departures from the norm, and one's colleagues.

Some matters involving standards that commonly need modification are as follows:

Hospital Visiting Hours

"Visiting hours" commonly coincide with times when adults are working and children are at school, thus making it difficult for friends and relatives to visit hospitalized patients. Also, the period assigned for visiting hours is often very short, affording the patients little time to spend with their visitors. In such cases the system neglects to recognize that most patients have families, that the patient's presence in the hospital is merely an accidental occurrence in his life, and that the situation through which he is living can be markedly brightened by the support, understanding, and presence of friends and family members.

Schedules

When a patient is in pain, nurses sometimes adhere strictly to the drug administration schedule for giving analgesics, or they delay giving the medication so that the patient "will have a good night." Both practices frequently occur without careful evaluation of the patient's pain and needs. As a result, analgesics are often administered at times indicated on the chart, or at times most convenient for the night staff, rather than when the patient really needs the medication.

Similarly, other schedules, including those for mealtimes and administration of a wide range of medications, are frequently geared to the service's smooth operation and the hospital staff's convenience rather than accommodation of the patients' needs and customary behavior patterns.

CASE 2: RESEARCH

Nurse 1: "They finally gave me the funds to try this new solution for cleaning eschars. Now I need to select the experimental and control groups."

Nurse 2: "You'll have to make sure the patients in the test group on whom you're going to try the solution are conscious and lucid, so that you can tell them what it's about and obtain their consent."

Nurse 1: "But do you really think that's so important? After all, it's not going to harm them."

To improve the quality of their care, nurses must study and try out new procedures calculated to benefit their patients. However, when a new technique or medication involving the patient is being tested, nurses are prone to commit two errors: neglecting to obtain or heed their patients' opinions and ignoring or bypassing the ethical standard requiring

that the patient's informed consent be obtained.

CASE 3: GOSSIP

Nurse 1 (on coffee-break): "I think the patient I've just admitted has AIDS! He's a well-known homosexual. . . . Even uses make-up. You should have seen the person who brought him in!"

Nurse 2: "You don't say. I'm going to take a look. What room is he in?"

Nurse 1: "He's in 2-A, beside the emphysema case, the one that's terminal."

Sometimes health care personnel make light or idle comments about a patient's circumstances that are unimportant to those talking but that could be extremely important to the patient.

Such gossip should be strongly discouraged, for professional confidentiality is one of the principal obligations of the nursing oath. The patient confides in the nursing professional as a result of his condition, and it is implicitly understood that the information provided will not be revealed. This understanding extends to all matters within the purview of the profession when disclosure might in any way harm the patient.

CASE 4: PRIVATE NURSING

Nurse 1 (at a private nursing bureau): "They're calling to ask for someone to take care of an incontinent old man who can't feed himself. They want someone who is good-natured, patient, and helpful."

Nurse 2: "We don't have anyone available right now. The only possibility would be to send Jane, but we don't know what she's like, she's only been here a week. . . . Well, let's send her anyway. After all, it's just an old man."

Scientific and technologic advances have brought changes to the nursing pro-

fession, especially regarding specialization and new kinds of care. This has had a major impact upon the field of private nursing—which has expanded recently and seems destined to grow more. Nevertheless, the nature of this type of nursing care continues to make it unusually vulnerable to ethical problems. Specifically, there is less opportunity for one professional to consult with another, less external control over the quality of care rendered, and none of the compulsory supervision that exists at health care facilities. These circumstances can significantly increase the risks to which the patient and his family are exposed.

Adding to the difficulty, early discharge of patients has become a common hospital practice. Such early discharge permits better utilization of hospital beds and provides multiple benefits for the patients and their families. But in many cases it also requires that home nursing care be provided by suitable and qualified personnel.

Within this context, the nurse's responsibility for delegating functions is a powerful tool subject to possible misuse. That is, ignorance of the particular status of a patient or of specific staff members' technical and moral qualifications can lead to decisions potentially harmful to the patient and his family. Therefore, in exercising this authority it is essential that the nurse be sensitive and assume an ethical responsibility that extends beyond the scope of her strictly legal obligations.

CASE 5: DYING WITH DIGNITY

Nurse: "Angelina, move the patient in bed seven to isolation; he is critical and needs to be alone. Alert the doctor and don't admit any visitors. . . ."

Aide: "I've already put the screen around his bed so the other patients in the room won't

see him, but if you like I'll move him to isolation."

Dialogues such as this are commonplace in hospitals, especially in the general medical and surgical services. The gravely ill patient who seems about to die tends to be isolated and removed from his roommates, possibly to prevent their confronting the frightening life experience that is the act of dying.

The nurse visits the patient when she has to perform routine control and treatment procedures. Her focus is on the execution of techniques, while interpersonal relations are avoided—perhaps out of fear, or perhaps because she is not prepared to stay with a dying patient, it being an "unlearned role" in our society.

We who typically avoid thinking about death commonly fail to realize that only to the extent that the nurse is capable of facing her own death will she really be able to help the patient undergoing this last and most solitary experience. Paradoxically, however, the patient who is dying asks very little of others: to be left alone with his loved ones and to receive spiritual aid in accord with his religious beliefs. From the nurse he asks specifically for a personal relationship: to listen to him and let him know, even without words, "I'm here beside you at this decisive moment."

As this suggests, care of a dying patient involves ethical responsibilities that the nurse should be aware of and for which she should be prepared—so that up to the last moment of his life the patient can receive the care his human condition merits and can die with dignity.

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New Ethics Center Formed by Nurses' Organization

The American Nurses' Association (ANA) has created a Center for Ethics and Human Rights, based in its Government Affairs office in Washington, D.C. (U.S.A.). The Center will develop and disseminate information on public policy and serve as an advocate to ensure that considerations of ethics and human rights are addressed in health care. It will also serve to integrate these concerns into all of ANA's activities, including its strategic plan, its labor relations, and its governmental practice program. The association's Executive Director, Barbara K. Redman, stated: "Nurses have historically been concerned with the rights of vulnerable population groups. The Center will enable nursing to develop a more unified voice on ethics and human rights and will provide stronger links with other groups that study these issues." The Center's Director is Gladys White, Ph.D., R.N., whose previous experience includes serving as a policy analyst and study director for the U.S. Office of Technology Assessment and holding research positions at the Kennedy Institute of Ethics (Georgetown University) and George Washington University, both in Washington, D.C.

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