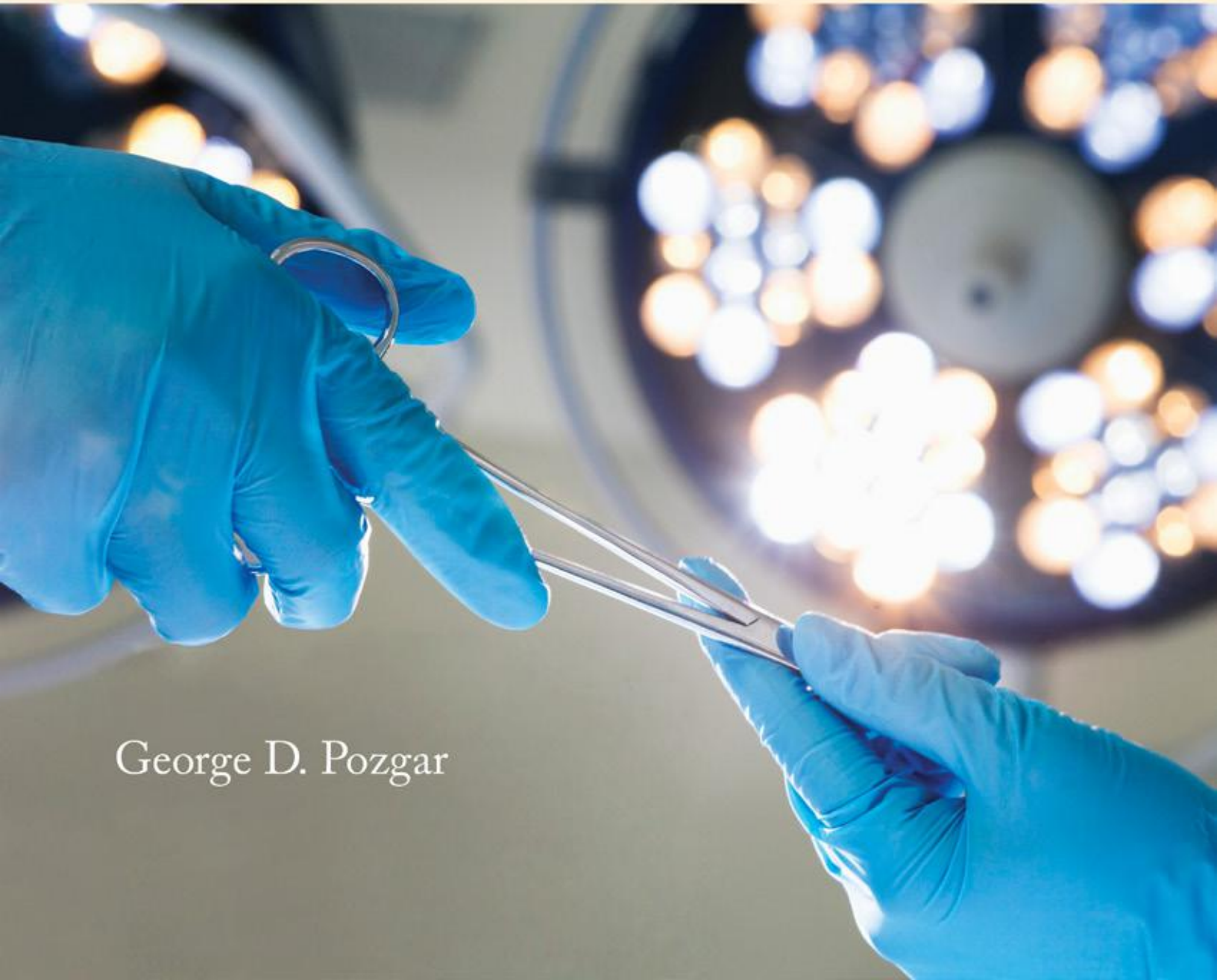
FIFTH EDITION

# LEGAL AND ETHICAL ISSUES

*for Health Professionals*



George D. Pozgar

FIFTH EDITION

# LEGAL AND ETHICAL ISSUES

## *for Health Professionals*

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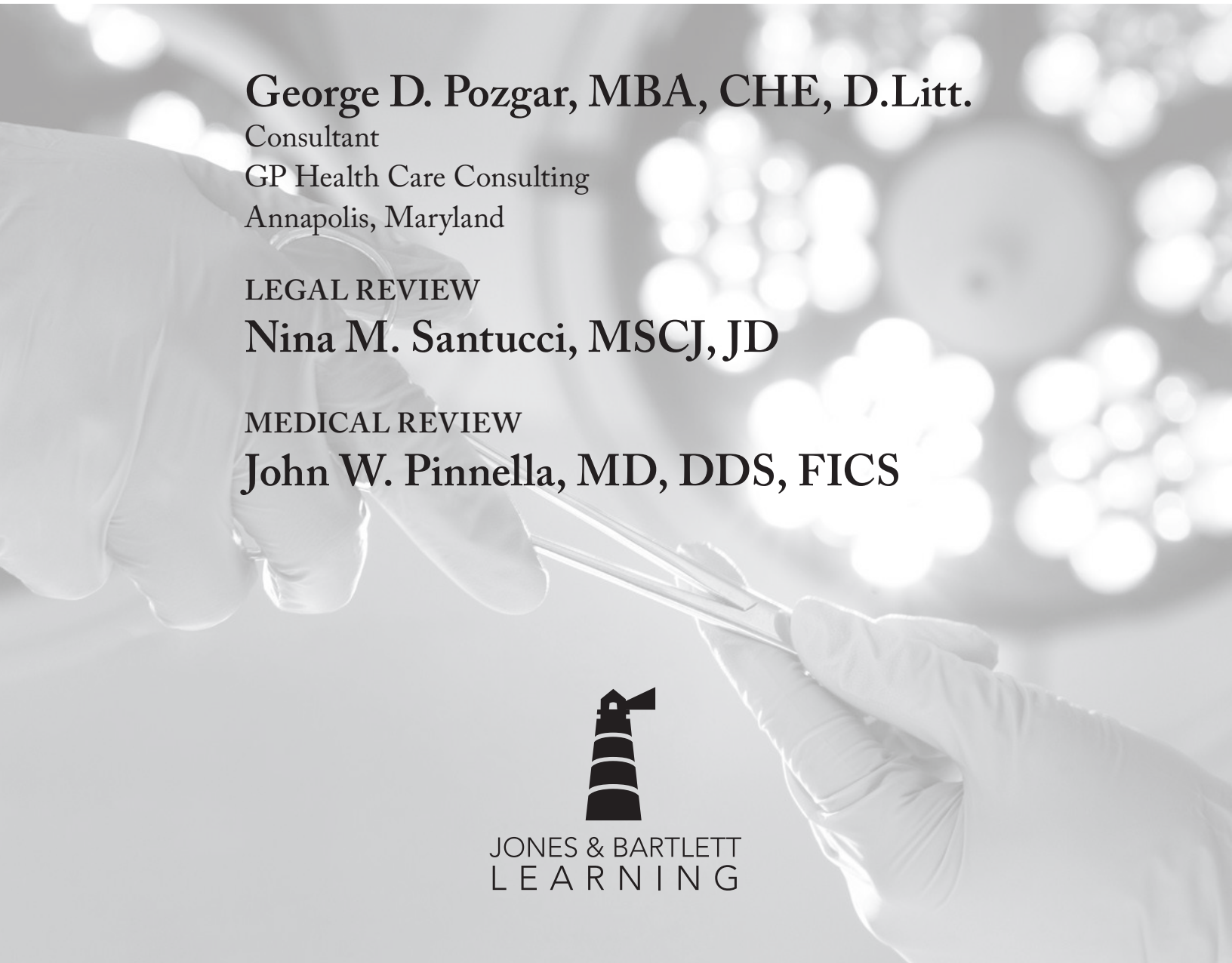

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*I dedicate this book to healthcare professionals who have chosen to serve in the noblest of professions, the healing ministry.*

*You stood by the bedsides of many patients during times of loneliness and frustration. When they wanted to give up, you gave them hope and the strength to fight on.*

*You watched over them while they slept, eased their pain with words of kindness, and gave them sips of water when they could not drink.*

*You stood by their bedside when fears arose within their souls.*

*Thank you, treasured caregivers, for you have been their light during the darkest of nights.*

*It has been my honor to have stood by your side as you provided care to so many patients as I surveyed your hospitals and ambulatory care sites.*

*It has been my privilege to have stood by those who I have taught, and those who have taught me.*

*Forever Thankful*

# Epigraph

*He has achieved success who has lived well, laughed often, and loved much; who has gained the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem, or a rescued soul; who has never lacked appreciation of earth's beauty or failed to express it; who has always looked for the best in others and given them the best he [or she] had; whose life was an inspiration; whose memory a benediction.*

—**Bessie Anderson Stanley**

*Every mistake brings a teaching moment, an opportunity to learn.*

—**Nina Santucci**

*Each life is like a novel. Filled with moments of happiness, sadness, crisis, defeat, and triumph. When the last page has been written, will you be happy or saddened by what you read?*

—**Author Unknown**

# Brief Contents

# Contents

# Foreword

The goal of this book is to help clarify the legal and ethical issues that are essential in the delivery of health care. Health care is perhaps the most personal of services anyone will receive in their lifetime. Our society regulates it with specific criteria for its administration. Much of this foundational information is concentrated in this convenient resource for students that will also aid healthcare workers and administrators in making better decisions for patient care.

Scientific advances in such areas as genetics and stem cell biology, nanotechnology, robotic surgery, tissue transplantation, and so much more promise humanity the potential for a longer, healthier, more optimistic future. The explosion of information technology is resulting in an exponential increase of scientific knowledge. Reaping the benefits of these advances can pose complicated considerations of safety, efficacy, availability, and affordability. The challenge is to administer rapidly changing healthcare science in a legal and ethical manner.

Legal and ethical parameters are subject to change, variable interpretation, and even contradiction. Codes of ethics and regulations vary among professional organizations, hospitals, and religions. Federal, state, and local laws may not be consistent. It can get complicated. Correct choices are not always obvious. Intuition and good intentions are not enough. That is why this book presents a coherent foundation of information from which to advance into the future. Making quality decisions in the administration of health care is the ultimate goal.

Dr. Pozgar has accumulated a wealth of information in this exhaustive review. The information presented here has been laboriously extracted from multiple sources and presented in logical order. Dr. Pozgar is perhaps the most relevant source, since he has had a lifetime of actual, real-world, practical experience as chief executive officer of a large hospital in a multi-hospital system, a Joint Commission hospital surveyor in literally hundreds of hospitals and ambulatory care sites, healthcare consultant in a wide variety of hospitals and medical centers, and a malpractice case reviewer for legal counsel. The result is this comprehensive text, which is a unique contribution to the improvement of patient care and which continues to be a classical reference work on the subject.

—John W. Pinnella, MD, DDS, FICS

# Preface

*Man's duty is to improve himself; to cultivate his mind; and, when he finds himself going astray, to bring the moral law to bear upon himself.*

—Immanuel Kant

## NEWS What's the One Thing You Would Invent If You Could?

A "decision-making" machine. You input your life dilemmas, and just like that, the right decision is displayed on a screen. The invention would save me so much time in torment.

—Caitlin Ghilarducci, *O, The Oprah Magazine*, August 2013

*Legal and Ethical Issues for Health Professionals, Fifth Edition*, has been designed to encourage the reader to learn the often-dreaded subject of ethics and the law while enjoying the journey from the didactics of the classroom to the practical application in the workplace. The *Fifth Edition* provides the reader with a clearer understanding of how the law and ethics are interwoven as they relate to healthcare dilemmas. The practical application of ethics in the healthcare setting is accomplished by interspersing the thoughts of great minds through **Quotes**; current healthcare events through **News Clippings**; human behavior through **Reality Checks**; and legal rulings and summaries through legal **Cases**. The book concludes with a courtroom drama that illustrates the complexities of human behavior, while tying together the contents of the book in one case.

The reader will learn how to evaluate and distinguish between the rightness and wrongness of alternative courses of action when faced with complex ethical dilemmas. Ethics in the healthcare setting focuses on doing the right thing for both patients and caregivers. When caregivers consider matters of law and ethics, they often involve matters of freedom in regard to personal choices, values, judgments about human character, and obligations to others.

This book, as with the previous editions, begins and ends with the premise that to act in an ethical manner requires the reader to engage in conduct according to generally accepted principles of right and wrong. The author's objective is therefore to provide the reader with a formidable and meaningful understanding of ethics and the law as they relate to addressing many of the more common ethical dilemmas encountered in the delivery of patient care and how to apply that knowledge in the healthcare setting. A study published in the *American Journal of Bioethics*, in a July 2008 article entitled "An Urgent Call for Ethics Education," describes the importance of ethics education and its influence on moral confidence and moral action.

To make good decisions, we must first understand that they will be only as good as our knowledge of what is right and what is wrong. There is a deluge of ethical issues in every aspect of human existence. Although cultural differences, politics, and religion influence who we are, it is all of life's experiences that affect who we will become.

Ethics and the law are interwoven. Ethics describes our values and morality—distinguishes good from evil. The law, on the other hand, describes our commonly accepted principles of good behavior and provides punishment for those who fail to adhere to these principles.

The cases presented here are not exhaustive for any one profession but often have application across all healthcare disciplines. Caregivers who have a clear grasp of the ethical and legal concepts discussed in this book will be better prepared to make healthcare decisions that are ethically sound and legally correct. Presented here is a sampling of the wide range of questions that can be asked and discussed when analyzing ethical dilemmas.

1. What are the relevant ethical and legal issues in the case?
2. What could have been done to bring more clarity to the ethical dilemma?
3. How should the legal issues of the case be addressed?

4. How might one's professional code of ethics be violated in the case?
5. How might the principles of patient autonomy, beneficence, nonmaleficence, and justice affect the decision-making process when faced with an ethical dilemma with legal implications?
6. What are the issues that could affect those involved in the resolution of an ethical dilemma (e.g., family members, physicians, and other caregivers, including nurses, chaplains, and/or ethics committee members)?
7. If you were friendly with the patient, would it affect your ability to give an objective opinion?
8. How can moral values, religious beliefs, education, and life experiences of both caregivers and patients complicate the resolution of healthcare dilemmas?
9. How can financial concerns affect the decision-making process?
10. How can corporate culture affect the decision-making process?

One of the most difficult things to come to terms within the decision-making process is to know when he endless loop of asking questions must end and a decision has to be made.

This *Fifth Edition* is not an indictment of any one profession or organization. It does, however, illustrate how a minority of people can often cast a dark shadow on the good that is done by so many for so many. Ethics is good people doing good things through acts of caring, compassion, and kindness.

It is comforting to know that some universities are helping to resolve the current healthcare financial crisis for those wishing to enter the field of medicine. The New York University School of Medicine, for example, is planning to offer free tuition to all current and future medical students. Robert I. Grossman, MD, the Saul J. Farber Dean of NYU School of Medicine and CEO of NYU Langone Health, stated: "This decision recognizes a moral imperative that must be addressed, as institutions place an increasing debt burden on young people who aspire to become physicians."[i] This same financial burden also exists for others with hopes of pursuing a health career. Ultimately, the hope is that more colleges and universities will follow suit by providing financial assistance to help address the financial needs of students in other health professions.

*The three hardest tasks in the world are neither physical feats nor intellectual achievements, but moral acts: to return love for hate, to include the excluded, and to say, "I was wrong."*

—Sydney J. Harris

## New to the *Fifth Edition*

The *Fifth Edition* of *Legal and Ethical Issues for Health Professionals* has been updated to expand discussion on difficult topics and includes a wide variety of current **News Clippings** and **Reality Checks**, which are real-life events experienced by both patients and healthcare professionals in leadership positions in the healthcare industry. These experiences include those of the author, incorporating his observations from a unique background as a hospital administrator in a multihospital system, instructor, author, consultant, and Joint Commission surveyor who conducted surveys of more than 1,000 hospitals and outpatient facilities from Alaska to Puerto Rico.

The author has made every attempt in this *Fifth Edition* to provide the student with the tools necessary for applying the law and ethics in the healthcare setting with the end goal of improving the professional's skills, performance, and decision-making processes.

The following is a summary of changes that have been made to improve the readability of the law and ethics content, which can be difficult topics for the reader to grasp owing to the need to learn new terminology, theories, and concepts that have substantial impact on each healthcare professional's daily tasks.

Chapter-specific changes are outlined in the following pages.

## Chapter 1: Introduction to Ethics

New or expanded topics include:

- Meta-ethics
- Tuskegee Syphilis Experiment
- Code of Conduct
- Morality Legislated
- Physicians and Paternalism
- Justice and Government Spending
- Injustice for the Insured
- Teaching Doctors to Care
- Fidelity
- Freedom
- Honesty/Trustworthiness/Truth Telling

[i]Alicia Ault, "NYU to Offer Free Tuition to All Current, Future Med Students," Medscape News (August 16, 2018). https://www.medscape.com/viewarticle/900860.

- Integrity
- Spiritual Health and Education
- Creating a Culture of Ethics
- Reasoning and the Decision-Making Process

The following **Reality Checks** have been added or revised:

- Paternalism and Breach of Confidentiality
- Man of Integrity

The following **News Clippings** have been added or revised:

- Abusing Assisted Suicide Laws
- WWII Veteran Calls for Help and Dies as Nurses Laugh, Video Shows
- Elderly Patient Hit by Motorcycle Dies in Japan After Being Rejected by 14 Hospitals
- Medical Errors Are Hard for Doctors to Admit

## Chapter 2: Contemporary Ethical Dilemmas

New or expanded topics include:

- Informed Consent
- Unethical Experiments on Children
- Radiation Experiments: Human Subjects Unaware
- Hospital Allowed to Remove Life Support: Contrary to the Wishes of the Legal Guardian
- UK Supreme Court Denies Right to Treatment
- Texas Restrictions on Women's Rights
- Abortions after 20 Weeks Prohibited
- Law and Morality of Abortion—Conflicting Beliefs
- Surrogacy
- Altruism vs. Sale of Organs
- Research, Experimentation, and Clinical Trials
- Institutional Review Board
- The Cures Act

The following **News Clipping** has been added:

- House Passes Bill That Would Give Patients Access to Experimental Drugs

## Chapter 3: End-of-Life Dilemmas

New or expanded topics include:

- Introduction
- Physician-Assisted Suicide
- Living Will
- Substituted Judgment
- Withholding and Withdrawal of Treatment
- A New Beginning and a Better Ending
- Administration on Aging

The following **News Clippings** have been added:

- Mom Wanted to Live on Her Own Forever
- Doctor Says Insurers Push Suicide Over Medical Care

## Chapter 4: Healthcare Ethics Committee

New or expanded topics include:

- Policy and Procedure Development
- Autonomy and the Law Collide
- A Statement Explaining a Patient's Right to Transfer is Now Included

## Chapter 5: Development of Law

New or expanded topics include:

- Public Law
- Administration on Aging
- National Institutes of Health
- Food and Drug Administration

The following **Reality Check** has been added:

- 50 and You Lived Your Life?

## Chapter 6: Introduction to Law

New or expanded topics include:

- Standard of Care Set by Statute
- Causation/Proximate Cause
- Assault and Battery
- Indictment
- Health Care Fraud
- Medical Identity Theft
- Contracts
- Summons and Complaint
- Burden of Proof
- Closing Statements
- Judge's Charge to the Jury

The following **News Clipping** has been added:

- National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for $1.3 Billion in Fraud Losses

## Chapter 7: Government Ethics and the Law

New or expanded topics include:

- U.S. Office of Government Ethics
- U.S. Judicial Code of Ethical Conduct
- State Ethics Committees
- Ethics in Public Service

The following **News Clipping** has been added:

- Poll: Americans Have Highest Trust in Military, While Congress and Media Fall Last

## Chapter 8: Organizational Ethics and the Law

New or expanded topics include:

- Fiduciary Responsibility
- Corporate Ethics
- Corporate Compliance Program
- Appointment of a CEO
- CEO Licensure
- CEO Responsibilities and Challenges
- Maintain Moral Integrity
- Provide Adequate Staff
- Provide Quality Patient Care
- Comply with Accreditation Standards
- Provide a Safe Environment
- Improving Organizational Performance and Ethics

The following **Reality Checks** have been added or revised:

- Ensuring Board Integrity
- Windows Wide Open

The following **News Clippings** have been added:

- Why So Many Doctors Kill Themselves
- Video of Md. Patient Put Out in Cold Stirs Fury

## Chapter 9: Healthcare Professionals Legal-Ethical Issues

New or expanded topics include:

- Paramedics and First Responders
- Nurse Practitioner
- Chiropractor
- Dietary
- Emergency Department: *Timely Response Required*
- Laboratory
- Pharmacy: *Reducing Medication Errors*
- Psychology
- Radiology

The following **Reality Check** has been added:

- Abnormal Laboratory Results Not Addressed

The following **News Clipping** has been added:

- Short on Staff: Nursing Crisis Strains U.S. Hospitals

The following **Case** has been revised:

- Case: Poor Judgment

## Chapter 10: Physician Ethical and Legal Issues

New or expanded topics include:

- Discharge and follow-up care

The following **Reality Checks** have been added or revised:

- Staff Lacks Compassion
- My Hopes for Help Crumble

The following **News Clippings** have been added:

- Doctors Perform Thousands of Unnecessary Surgeries
- Your Doctor Is Here and There
- Is U.S. Medicine Becoming Assembly Line Medicine?

## Chapter 11: Employee Rights and Responsibilities

The following **Reality Checks** have been added:

- Dear Dr. XYZ
- Multidisciplinary Approach to Patient Care

## Chapter 12: Patient Consent

The following **News Clippings** have been added:

- Surgery to Ease Pain Sounded Really Simple
- Eastern Shore Doctor Convicted of Criminal Charges in Stent Case

## Chapter 13: Patient Abuse

New or expanded topics include:

- Abusers Abused
- Prevention of Senior Abuse

## Chapter 14: Patient Rights and Responsibilities

New or expanded topics include:

- Right to Try Experimental Drugs

The following **Reality Checks** have been added or revised:

- Right to Complain
- Your Dad Is an Example of Why Healthcare Costs Are Excessively High
- Why Must I Fear?
- Over-Surveyed vs. Under-Surveyed

The following **News Clipping** has been added:

- Suddenly, Unexpectedly, He Grabs My Shirt. "Don't Let Me Die!" He Says, Spraying Me with Blood.

## Key Features

- **Quotes** The practical application of ethics in the healthcare setting is accomplished by interspersing the thoughts of great minds through Quotes
- **News Clippings** The legal and ethical issues of current healthcare events are reviewed and explored as News Clippings of actual published editorials
- **Reality Checks** Patient, personal, provider, and organizational experiences are shared through Reality Checks
- **Cases** Legal rulings and summaries are showcased through Case Law examples
- **Summary Case** The book concludes with a closet drama that illustrates the real world of human behavior and ties together its contents in one case

## Instructor Resources

*Qualified Instructors will receive a full suite of Instructor Resources, including the following:*

- More than 250 Slides in PowerPoint format
- A Test Bank with chapter-by-chapter questions alone with a midterm and a final
- An Instructor's Manual containing a summary, teaching tips, and suggested classroom activities

# Acknowledgments

I would be remiss if I failed to acknowledge my publisher, Mike Brown, who was the inspiration for this particular text. Without him, the book would never have been written. Thank you for encouragement and for believing and trusting in me over the years.

The author especially acknowledges the staff at Jones & Bartlett Learning, whose guidance and assistance were so important in making this *Fifth Edition* of *Legal and Ethical Issues for Health Professionals* a reality. Special thanks to Cathy Esperti during the signing stage of the *Fifth Edition*; Rachael Souza, who worked tirelessly during the editorial stages; the project specialists, Nancy Hitchcock and Alex Schab; Thais Miller in Rights & Media; Shannon Sheehan, the media developer; and the all-important Michael Sullivan in marketing. As with the publication of any book, there are numerous people behind the scenes with whom I have not dealt with directly. Please know that your hard work is much appreciated. Thanks to all for allowing me to leave behind this legacy of writing.

I am grateful to the very special people in the more than 1,000 hospitals and ambulatory sites from Alaska to Puerto Rico with whom I have consulted, surveyed, and provided education over many years. Their shared experiences have served to remind me of the importance in design of this book to ensure its value in the classroom as well as its ongoing reference value for practicing healthcare professionals.

To my students in healthcare law and ethics classes at the New School for Social Research, Molloy College, Long Island University–C.W. Post Campus, Saint Francis College, and Saint Joseph's College; my intern from Brown University; my resident in hospital administration from The George Washington University; and those I have instructed throughout the years at various seminars, I will always be indebted to you for your inspiration.

Many thanks are also extended to all those special people at the National Library of Medicine and the Library of Congress for their guidance over the years in locating research materials.




CHAPTER 1

# Introduction to Ethics

*I expect to pass through this world but once. Any good therefore that I can do, or any kindness I can show to any creature, let me do it now. Let me not defer it, for I shall not pass this way again.*

—Stephen Grellet

## LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

- Explain what ethics is, its importance, and its application to ethical dilemmas.
- Describe the concepts of morality, codes of conduct, and moral judgments.
- Understand relevant ethical theories and principles.
- Describe virtue ethics and values and how they more clearly describe one's moral character.
- Understand how religious ethics can affect one's moral character.
- Explain the concept of situational ethics and how changes in circumstances can alter one's behavior.
- Understand the importance of reasoning in the decision-making process.

# INTRODUCTION

*Good can triumph over evil.*

—Author Unknown

This chapter provides an overview of the study of ethics as it relates to the delivery of patient care. The intent here is not to burden the reader with complex philosophical theories; however, as with the study of any new subject, *words are the tools of thought*, and thus an overview and basic understanding of ethics is necessary to help the reader more effectively address many of the common ethical dilemmas that often confront caregivers in the delivery of patient care. Although ethical concepts are often thought of in daunting philosophical terms, the reader who grasps and applies the theories and principles of ethics discussed here will have the tools necessary to empathize with and guide patients, families, and caregivers through the conflicts they often encounter when making care decisions. Therefore, some new vocabulary is a necessary tool, as a building block for the reader to establish a foundation for applying the abstract theories and principles of ethics in order to put them to practical use. Just as the directions on a map are of little value until one makes the journey, so it is with ethics; caregivers must begin to make the journey by learning the thought processes that will help guide the caregiver when addressing complex ethical dilemmas. The learning process for ethics becomes a more enjoyable and rewarding journey as we grasp the ideas, build upon them, and practice all the good we learn by helping all the people we can for as long as we can.

# ETHICS

*How we perceive right and wrong is influenced by what we feed on.*

—Author Unknown

*Ethics* is the branch of philosophy that seeks to understand the nature, purposes, justification, and founding principles of moral rules and the systems they comprise. Ethics and morals are derivatives from the Greek and Latin terms (roots) for *custom*. The etymology of the words "ethics" and "morality" is derived from the roots *ethos* and *mos*, which both convey a meaning describing customs or habits. This etymology supports the claims of anthropologist Ruth Benedict that all values are rooted in customs and habits of a culture, because the words *moral* and *ethics* themselves were essentially created to describe these topics.[1]

Ethics deals with values relating to human conduct. It focuses on the rightness and wrongness of actions, as well as the goodness and badness of motives and ends. Ethics encompasses the decision-making process of determining ultimate actions—that is, answering the questions *What should I do?* and *Is it the right thing to do?* Ethics is an expression of how individuals decide to live with one another within accepted boundaries and how they live in harmony with the environment as well as one another. Ethics is concerned with human conduct as it ought to be, as opposed to what it actually is.

*Microethics* involves an individual's view of what is right and wrong based on one's personal life teachings, traditions, and experiences. *Macroethics* involves a more global view of right and wrong. Although no person lives in a vacuum, solving ethical dilemmas involves consideration of ethical issues from both a micro and macro perspective.

*Man's duty is to improve himself; to cultivate his mind; and, when he finds himself going astray, to bring the moral law to bear upon himself.*

—Immanuel Kant

The term *ethics* is used in three distinct but related ways, signifying (1) *philosophical ethics*, which involves inquiry about ways of life and rules of conduct; (2) a *general pattern or way of life*, such as religious ethics (e.g., Judeo-Christian ethics); and (3) a *set of rules* of conduct or "moral code" (e.g., professional codes for ethical behavior).

The scope of healthcare ethics encompasses numerous issues, including the right to choose or refuse treatment and the right to limit the suffering one will endure. Incredible advances in technology and the resulting capability to extend life beyond what might be considered a reasonable quality of life have complicated the process of healthcare decision making. The scope of healthcare ethics is not limited to philosophical issues but embraces economic, medical, political, social, and legal dilemmas.

*Bioethics* addresses a diversity of issues that include the nature of life and death, what sort of life is worth living, how we distinguish between assisted suicide and murder, how we should treat people who are especially vulnerable, and the responsibilities that we have toward other human beings. It is about making better decisions when addressing diverse complex care issues with a wide variety of circumstances.

## Why Study Ethics

We study ethics to help caregivers make sound judgments, good decisions, and right choices; if not right choices, then better choices. To those in the healthcare

industry, it is about anticipating and recognizing healthcare dilemmas and making good judgments and decisions based on universal values that work in unison with the laws of the land and our Constitution. Where the law remains silent, we rely on the ability of caregivers to make sound judgments, guided by the Wisdom of Solomon to do good. Doing the right thing by applying the universal morals and values described in this text (e.g., the 10 Commandments) will help shield and protect all from harm.

## MORALITY

*The three hardest tasks in the world are neither physical feats nor intellectual achievements, but moral acts: to return love for hate, to include the excluded, and to say, "I was wrong."*

—Sydney J. Harris

The following **News Clippings** portray how a deficiency in the morality of society can lead to a betrayal of humanity. Lawlessness and heartless actions run rampant in a land void of courage and compassion. The reader who thoroughly absorbs, understands, and practices the virtues and values discussed in the pages that follow will see hope spring forth in what often seems a desperate and hopeless world.

### NEWS Vietnam—Terror of War

Fire rained down on civilians. Women and children ran screaming. Ut snapped pictures. A little girl ran toward him, arms outstretched, eyes shut in pain, clothes burned off by napalm. She said, "Too hot, please help me!"

—1973 Spot News, Newseum, Washington, DC

### NEWS Ethiopian Famine (1985 Feature)

People searched everywhere for food. Some 30,000 tons of it, from the United States, had been held up by an Ethiopian government determined to starve the countryside into submission. And starve the people it did—half a million Ethiopians, many of them children so hungry their bodies actually consumed themselves.

I'll never forget the sounds of kids dying of starvation.

—Newseum, Washington, DC

### NEWS Waiting Game for Sudanese Child . . .

Carter's winning photo shows a heartbreaking scene of a starving child collapsed on the ground, struggling to get to a food center during a famine in the Sudan in 1993. In the background, a vulture stalks the emaciated child.

Carter was part of a group of four fearless photojournalists known as the "Bang Bang Club" who traveled throughout South Africa capturing the atrocities committed during apartheid.

Haunted by the horrific images from Sudan, Carter committed suicide in 1994 soon after receiving the award.

—A Pulitzer-Winning Photographer's Suicide, *National Public Radio (NPR)*, March 2, 2006

*Trek of tears describes many horrible historic events, from broken treaties with American Indians to an African journey of horror, where people would flee together as a village to escape the barbaric slaughter of men, women, and children as the remainder of the world stood cowardly by watching the death and starvation of hundreds of thousands of people. Human atrocities committed by humans. Is it not time to stand up and be counted on to do what is right and leave all excuses behind for our complacency toward the genocide that continues throughout the world?*

—GP

*There are those who have been brainwashed into believing, in the name of religion, that if they blow themselves up in public places, killing innocent people, that they will be rewarded in the afterlife. This is not religion and it is not culture; it is evil people brainwashing young minds to do evil things.*

—GP

*Aim above morality. Be not simply good; be good for something.*

—Henry David Thoreau

*Morality* describes a class of rules held by society to govern the conduct of its individual members. It implies the quality of being in accord with standards of right and good conduct. Morality is a code of conduct. It is a guide to behavior that all rational persons should put forward for governing their behavior. Morality requires us to reach a decision as to the rightness or wrongness of an action. *Morals* are ideas about what is right and what is wrong; for example,

killing is wrong, whereas helping the poor is right, and causing pain is wrong, whereas easing pain is right. Morals are deeply ingrained in culture and religion and are often part of its identity. Morals should not be confused with religious or cultural habits or customs, such as wearing a religious garment (e.g., veil, turban). That which is considered morally right can vary from nation to nation, culture to culture, and religion to religion. In other words, there is no universal morality that is recognized by all people in all cultures at all times.

## Code of Conduct

A *code of conduct* generally prescribes standards of conduct, states principles expressing responsibilities, and defines the rules expressing duties of professionals to whom they apply. Wikipedia describes a *code of conduct* as a "set of rules outlining the social norms, religious rules and responsibilities of, and or proper practices for, an individual, party or organization. Related concepts include ethical, honor, moral codes and religious laws."[2] Most members of a profession subscribe to certain "values" and moral standards written into a formal document which describes the organization's code of conduct. Codes of conduct often require interpretation by caregivers as they apply to the specific circumstances surrounding each dilemma.

Michael D. Bayles, a famous author and teacher, describes the differences between standards, principles, and rules:

- *Standards* (e.g., honesty, respect for others, conscientiousness) are used to guide human conduct by stating desirable traits to be exhibited and undesirable ones (dishonesty, deceitfulness, self-interest) to be avoided.
- *Principles* describe responsibilities that do not specify what the required conduct should be. Professionals need to make a judgment about what is desirable in a particular situation based on accepted principles.
- *Rules* specify specific conduct; they do not allow for individual professional judgment.

## Moral Judgments

*Moral judgments* are those judgments concerned with what an individual or group believes to be the right or proper behavior in a given situation. Making a moral judgment is being able to select an option from among choices. It involves assessing another person's moral character based on how he or she conforms to the moral convictions established by the individual and/or group. A lack of conformity can result in moral disapproval and possibly ridicule or censure of one's character.

## Morality Legislated

When it is important that disagreements be settled, morality is often legislated. Law is distinguished from morality by having explicit rules and penalties, as well as officials who interpret the laws and apply penalties when laws are broken. There is often considerable overlap in the conduct governed by morality and that governed by law. Laws are created to set boundaries for societal behavior. They are enforced to ensure that the expected behavior happens.

"You can't legislate morality" has become a common turn of phrase. The truth is, however, that every law and regulation that is proposed, passed, and enforced has inherent in it some idea of the good that it seeks to promote or preserve. Indeed, no governing authority can in any way be understood to be morally neutral. Those who think such a chimerical understanding is possible could hardly be more wrong. For, in fact, the opposite is true: You can't *not* legislate morality.

## Moral Dilemmas

*Moral dilemmas* in the healthcare setting often arise when values, rights, duties, and loyalties conflict. Caregivers often find that there appears to be no right or wrong answer when faced with the daunting task of determining which decision path to follow. The best answer when attempting to resolve an ethical dilemma includes the known wishes of the patient and other pertinent information, such as a living will, that might be available when the patient is considered incompetent to make his or her own choices. The right answer is often elusive when the patient is in a coma, there are no known documents expressing a patient's wishes, and there are no living relatives. However, an understanding of the concepts presented here will assist the caregiver in resolving complex ethical dilemmas.

# ETHICAL THEORIES

*Ethics, too, are nothing but reverence for life. This is what gives me the fundamental principle of morality, namely, that good consists in maintaining, promoting, and enhancing life, and that destroying, injuring, and limiting life are evil.*

—Albert Schweitzer

Ethics seeks to understand and to determine how human actions can be judged as right or wrong. Ethical judgments can be made based on our own experiences or based upon the nature of or principles of reason.

The *theories and principles of ethics* introduce order into the way people think about life. They are the foundations of ethical analysis that provide guidance in the decision-making process. The various theories present differing viewpoints that assist caregivers in making difficult decisions that impact the lives of others. Ethical theories help caregivers determine the outcome of alternative choices, when following their duties to others, in order to reach the best ethical decision under the circumstances. The more commonly discussed ethical theories are presented here.

## Meta-Ethics

*Meta-ethics* is the study of the origin and meaning of ethical concepts. Meta-ethics seeks to understand ethical terms and theories and their application. "Meta-ethics explores as well the connection between values, reasons for action, and human motivation, asking how it is that moral standards might provide us with reasons to do or refrain from doing as it demands, and it addresses many of the issues commonly bound up with the nature of freedom and its significance (or not) for moral responsibility."[3] Meta-ethics is "A classification within western philosophy that attempts to discover the origin or cause of right and wrong."[4]

An example question within meta-ethics is: "How can we know what is right and wrong?" There are almost as many different answers as there are different people answering the question. Some individuals may say that right and wrong are dictated by holy books, or philosophy books, or political books, or by popular speakers, but there is no good explanation yet within philosophy that can illustrate the origins and nature of right and wrong that are verifiable and acceptable to everyone.[5]

A patient faces illness, disease, and end-of-life issues as a result of all of his life experiences. The caregiver must be committed to understanding and accepting that people have different viewpoints when facing end-of-life decisions in order to better help the patient in his journey through the fears and ups and downs of illness. "Comfort care is an essential part of medical care at the end of life. It is care that helps or soothes a person who is dying. The goals are to prevent or relieve suffering as much as possible and to improve quality of life while respecting the dying person's wishes."[6]

## Normative Ethics

*Normative ethics* is prescriptive in that it attempts to determine what moral standards should be followed so that human behavior and conduct may be morally right. Normative ethics is primarily concerned with establishing standards or norms for conduct and is commonly associated with investigating how one ought to act. It involves the critical study of major moral precepts, such as what things are right, what things are good, and what things are genuine. One of the central questions of modern normative ethics is whether human actions are to be judged right or wrong solely according to their consequences.

The determination of a universal moral principle for all humanity is a formidable task and most likely not feasible due to the diversity of people and their cultures. However, there is a need to have a commonly held consensus about what is right and wrong in order to avoid chaos. Thus, there are generally accepted moral standards around which laws are drafted.

### *Normative Ethics and Assisted Suicide*

Oregon's Death with Dignity Act of 1997 allows terminally ill state residents to end their lives through the voluntary self-administration of a lethal dose of medications prescribed by a physician.[7] Although this act was voted upon by the Oregon state legislature and agreed upon by referendum, there are those who disagree with the law from a religious or moral standpoint. The Oregon act is controversial at best and has placed morality and the law in conflict. In the middle of the continuing controversy is the terminally ill patient, who must make the ultimate decision of life versus death. It could be argued that it is morally wrong to take one's own life regardless of the law, or it can be argued that ending one's life is a morally permissible right because the law provides the opportunity for terminally ill patients to make end-of-life decisions that include the right to self-administer a lethal dose of medications.

As there is a diversity of cultures, there is diversity of opinions as to the rightness and wrongness of the Oregon act. From a microethics point of view as it relates to the Oregon law, each individual must decide what is the right thing to do.

## Descriptive Ethics

*Descriptive ethics*, also known as comparative ethics, is the study of what people believe to be right and wrong and why they believe it. Descriptive ethics describes how people act, "and/or what sorts of moral standards

they claim to follow,"[8] whereas normative ethics prescribes how people ought to act. Both normative and descriptive ethical theories have application in the Oregon act. The controversial nature of physician-assisted suicide in the various states is but one of many healthcare dilemmas caregivers will experience during their careers (e.g., abortion, euthanasia, ***right to try experimental drugs***).

## Applied Ethics

*Applied ethics* is "the philosophical search (within western philosophy) for right and wrong within controversial scenarios."[9] Applied ethics is the application of normative theories to practical moral problems, such as abortion, euthanasia, and assisted suicide.

## Consequential Ethics

*The end excuses any evil.*

—Sophocles, *Electra* (c. 409 B.C.)

The theory of consequential ethics emphasizes that the morally right action is whatever action leads to the maximum balance of good over evil. From a contemporary standpoint, theories that judge actions by their consequences have been referred to as *consequential ethics*. Consequential ethical theories revolve around the premise that the rightness or wrongness of an action depends on the consequences or effects of an action. The theory of consequential ethics is based on the view that the value of an action derives solely from the value of its consequences. The consequentialist considers the morally right act or failure to act is one that will produce a good outcome. The goal of a consequentialist is to achieve the greatest good for the greatest number. It involves asking such questions as:

- What will be the effects of each course of action?
- Who will benefit?
- What action will cause the least harm?
- What action will lead to the greatest good?

These questions should be applied when answering the questions in the following **Reality Check**.

### REALITY *No Good Deed Goes Unpunished*

Matt was assigned to survey Community Medical Center (CMC) in Anytown, Minnesota, with a team of three surveyors and one observer. He related to me his experience of surveying the children's dental clinic.

Following his tour of CMC's dental clinic, Matt reviewed with the clinic's staff the dental program, which served the city's underserved children. He also reviewed the care rendered to several patients based on common and complex diagnoses, as well as the clinic's performance improvement activities. During the survey, Dr. Seiden, the clinic director, asked, "Are surveyors trained about the importance of dental care in disease prevention? As you know, dentistry is often a stepchild when it comes to allocation of scarce resources. Departments like surgery and radiology often receive the lion's share of funds." Matt responded by describing a film sponsored by the American Dental Association that was shown when he was in training to become a surveyor. The film presented a man whose dental care had been sorely neglected throughout his life and not been addressed prior to replacement of a heart valve. The patient developed a systemic infection following surgery, which led to deterioration of the heart valve and the patient's ultimate death. The film described the lessons learned and opportunities for performance improvement that included the need for a dental evaluation by a dentist prior to valve replacement. Dr. Seiden was pleased to learn that the importance of dentistry is included in surveyor training.

Following Matt's survey of the dental clinic, the staff relayed to him their concern that the clinic was going to be closed for lack of funds. Cheryl, the clinic manager, explained, "I sometimes feel the importance of the dental clinic to the underserved population is not well-understood." A bit emotional, Cheryl said, "Matt, have you surveyed other dental clinics?" Matt replied, "Yes, several well-funded clinics that come to mind were in Philadelphia and New York City." Cheryl then asked, "Matt, do you have any ideas as to how we can save our clinic from closing?" Matt replied, "I have some time before lunch, and I can share a few ideas with you." Cheryl replied, "The staff will be eager to listen." The staff proceeded to place several chairs in a semicircle and brainstormed with Matt a variety of ideas for saving the clinic. The staff discussed several fund-raising activities including a car wash by children to bring awareness to Anytown's dental clinic. Matt looked at his watch and said, "I need to get back to my survey team, but I want to leave you with one other thought to ponder that could be applicable to any department in the hospital. I was surveying a veteran's hospital physical therapy department and noticed on their bulletin board the staff's dream plan for renovation of their department. I asked the physical therapy staff about the plan. They related how their vision of a new physical therapy department had been sketched out and placed on their bulletin board. Several weeks later, a veteran who had been sitting in the waiting area became curious about their dream. After studying the board during his visits for therapy, he walked to the reception desk

on his last visit and asked about their vision for physical therapy. They explained it was a $200,000 dream. Gary looked at the staff at the reception desk and said, 'It is no longer a dream. I don't have much, but what I do have is enough to make your dream come true.' And, so he did." Matt continued, "You see, if people know your dreams, something as small as a bulletin board can make all the difference." Dr. Seiden smiled and said, "I see where this is going: community awareness as to the need to fund the clinic. It's really not merely about a car wash, it's about a concept of how the hospital can save not only the dental clinic but other programs earmarked for closing." Matt smiled, as the staff regained hope. Dr. Seiden, seeing that Matt had little time for lunch, stood up, extended his hand and said, "Matt, you gave us hope when we believed there was none. Thank you so much. I will be sure to discuss this with administration."

Matt presented his observations the following morning to the organization's leadership, which included his roundtable discussion with the staff. He was, however, cut short in his presentation by the surveyor team leader, Brad, who later reported to Victor, Matt's manager, that Matt should not be discussing how to save a dental clinic by opening a car wash. Matt received a reprimand from Victor and was removed at the end of day 4 of a 5-day survey without explanation.

—Anonymous

***Discussion***

1. Discuss Matt's approach to addressing the staff's concerns for saving the children's dental clinic.
2. If Matt's roundtable session led to saving the clinic, was Matt's reprimand worth the risk if he could have foreseen the resulting reprimand?
3. The goal of a consequentialist is to achieve the greatest good for the greatest number. Discuss how this applies in this Reality Check.

## Utilitarian Ethics

*Happiness often sneaks in a door you did not think was open.*

—Author Unknown

The utilitarian theory of ethics involves the concept that the moral worth of an action is determined solely by its contribution to overall usefulness. It describes doing the greatest good for the greatest number of people. It is thus a form of *consequential ethics*, meaning that the moral worth of an action is determined by its outcome, and, thus, the ends justify the means. The utilitarian commonly holds that the proper course of an action is one that maximizes utility, commonly defined as maximizing happiness and reducing suffering, as noted in the following **Reality Check**.

### REALITY Maximizing Happiness and Reducing Suffering

Daniel was the last of five people interviewed for the CEO's position at Anytown Medical Center. During the interview, a member of the finance committee asked, "Daniel, how would you maximize an allocation of $100,000 to spend as you wished for improving patient care, aside from capital budget and construction projects?" Bishop Paul, the board chairman, added, "Daniel, think about the question. I will give you five minutes to form an answer." Daniel responded, "Bishop Paul, I am ready to answer your question now." The trustees looked somewhat surprised, as Bishop Paul quickly responded with a smile, "You may proceed with your answer." Daniel replied, "An old Chinese proverb came to mind as quickly as the question was asked: 'Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime.' You are interviewing me as CEO of your hospital. I see my job as assuring you that employees are thoroughly trained to care for the patients the hospital serves. I will maximize the value of each and every dollar by determining skill sets that the staff are lacking and retraining staff in the areas where deficiencies are noted."

Bishop Paul looked around the long oval table at the trustees. "This has been a long day and a grueling interview process for Daniel. Are there any other questions you would like to ask him?" There was silence as the trustees shook their heads. Bishop Paul looked at Daniel and thanked him for his interest in becoming the hospital's next CEO.

As Daniel began to leave the boardroom, Bishop Paul smiled and turned his swivel chair around as Daniel was walking toward the exit and asked, "Daniel, could I ask that you not leave the building just yet? If you could, just wait

*(continues)*

## REALITY Maximizing Happiness and Reducing Suffering *(continued)*

outside the room and have a seat in the doctors' lounge area." After about 20 minutes, a trustee went into the lounge where Daniel was sitting and asked him to return to the boardroom. As he entered the room, Bishop Paul stood up and looked at Daniel straight in his eyes and said, "Daniel, you were the last to be interviewed because you were on the short list of candidates selected to be interviewed. Speaking for the board, your response to the last question was merely icing on the cake confirming our interest in you joining our staff. Both the Board of Trustees and members of the Medical Executive Committee unanimously have recommended you as our CEO, with which I unconditionally concur! Welcome to Anytown Hospital." The trustees stood and clapped their hands. The bishop turned to the trustees and said, "Wow, that's a first."

—Anonymous

***Discussion***

1. Discuss how Daniel's response to the trustee's question of how he would spend the $100,000 fits the utilitarian theory of ethics.
2. Did Daniel, metaphorically speaking, succeed in maximizing happiness in the eyes of the board? Discuss your answer.

## Deontological Ethics

*Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end.*

—Immanuel Kant

*Deontological ethics* is commonly attributed to the German philosopher Immanuel Kant (1724–1804). Kant believed that although doing the right thing is good, it might not always lead to or increase the good and right thing sought after. It focuses on one's duties to others and others' rights. It includes telling the truth and keeping your promises. Deontology ethics is often referred to as duty-based ethics. It involves ethical analysis according to a moral code or rules, religious or secular. *Deon* is derived from the Greek word meaning "duty." Kant's theory differs from consequentialism in that consequences are not the determinant of what is right; therefore, doing the right thing may not always lead to an increase in what is good.

Duty-based approaches are heavy on obligation, in the sense that a person who follows this ethical paradigm believes that the highest virtue comes from doing what you are supposed to do—either because you have to, for example, following the law, or because you agreed to, for example, following an employer's policies. It matters little whether the act leads to good consequences; what matters is "doing your duty."[10] The following **Reality Check** illustrates how duty-based ethics focuses on the act and not the consequences of an act.

## REALITY Duty Compromises Patient Care

At 33 years of age, Daniel was the youngest administrator in New York State and was about to learn that adhering to company policy sometimes conflicts with the needs of the patient. In this case, it was a 38-year-old employee who had been diagnosed with cancer. He remembers the day well, even though it was more than 30 years ago. His secretary alerted him that Carol, a practical nurse and employee, had been admitted to the 3-North medical-surgical unit, where she worked. Without delay, he left his office and went to the nursing unit and inquired as to what room Carol was in. Beth, the unit's nurse manager, overheard the question. She walked up and asked, "Daniel, could I please talk to you for a moment before you visit with Carol?" He looked at her and nodded yes and without thought, they both walked to her office. She closed the door and said, "As you know, we are self-insured, and the health insurance program we have does not cover Carol's chemotherapy treatments. She cannot bear the cost. Is there anything you can do to help her?" Daniel replied that he would make an inquiry with the human resources director to see what could be done.

Beth asked, "Would you mind if I went with you to Carol's room for a few minutes?" Daniel compassionately replied, "Of course you can."

They walked to Carol's room. Her husband and children had just left. Beth stayed for only a few minutes, and while Daniel remained behind, chatting with Carol for a few moments, and said he would be back to talk with her more.

Daniel went to speak with Christine, the hospital's human resources director. There were two other hospitals in the multihospital system. He explained Carol's financial situation and her lack of funds for chemotherapy treatment. Christine replied, "Daniel, this is corporate policy that is applicable to all three hospitals with which we must comply. We do not include chemotherapy treatment in the hospital's self-insurance plan for employees." Following much discussion, Daniel said, "Christine, Carol is an employee, and I realize there are conflicting duties here. One is to follow corporate policy, and the other is to choose to do, as I see it, what is right for Carol. If you prefer, I can request an exception to the rule. To me, right trumps duty." Christine looked at Daniel and said, "Daniel, I will see what I can do. I have a good relationship with the corporate vice president for human resources. If anyone can make an exception, he can make it happen. I know you would do the same for me and any other employee."

—Anonymous

***Discussion***

1. Discuss the potential long-term effect of granting an exception for Carol.
2. Do you believe that duty should be trumped by good? Discuss your answer.
3. Would you describe Daniel as consequentialist because he favors evaluating the outcome of an act rather than the act itself? Discuss your answer.
4. Discuss how deontological ethics in this case is in conflict with consequential thinking.

## Nonconsequential Ethics

The *nonconsequential ethical theory* denies that the consequences of an action are the only criteria for determining the morality of an action. In this theory, the rightness or wrongness of an action is based on properties intrinsic to the action, not on its consequences. In other words, the nonconsequentialist believes right or wrong depends on the intention, not the outcome.

### REALITY Bad Outcome, Good Intentions

Chelsea was preparing to drape Mr. Smith's leg in OR 6 for surgery, when she was approached by Nicole, the nurse manager, and asked, "Chelsea, please come to OR 3. We have an emergency there and urgently need your skills to assist the surgeon." Chelsea turned to Daniel, the surgical technician, and asked him to continue prepping Mr. Smith's leg for surgery. Daniel prepped the leg prior to the surgeon entering the room. The surgeon entered the room a few minutes later and asked, "Where is Chelsea?" Daniel replied, "She was called away for an emergency in OR 3. Karen will be in shortly to assist us."

Following surgery, Mr. Smith was transferred to the recovery room. While he was in the recovery room, a nurse was looking at the patient's medical record as to the notes regarding the patient's procedure during surgery. She noticed that surgery was conducted on the wrong leg.

Although there was heated discussion between the surgeon and nursing staff, each member of the staff had good intentions, but the outcome was not so good. Nonconsequentialists believe that right or wrong depends on the intention. They generally focus more on deeds and whether those deeds are good or bad. In this case, the intentions were good, but the outcome was bad. It should be noted that nonconsequentialists do not always ignore the consequences. They accept the fact that sometimes good intentions can lead to bad outcomes. In summary, nonconsequentialists focus more on character as to whether someone is a good person or not. Nonconsequentialists believe that right or wrong depends on the intention. Generally, the consequentialist will focus more on outcomes as to whether or not they are good or bad.

***Discussion***

1. Describe how the nonconsequential theory of ethics applies in this case.
2. What questions might the consequentialist raise after reviewing the facts of this case?

## Ethical Relativism

The theory of *ethical relativism* holds that morality is relative to the norms of the culture where one lives. In other words, right or wrong depends on the moral norms of the society in which it is practiced. A particular action by an individual may be morally right in one society or culture and wrong in another. What is acceptable in one society may

not be considered as such in another. Slavery may be considered an acceptable practice in one society and unacceptable and unconscionable in another. The administration of blood may be acceptable as to one's religious beliefs and not acceptable to another within the same society. The legal rights of patients vary from state to state, as is well borne out, for example, by Oregon's Death with Dignity Act. Caregivers must be aware of cultural, religious, and legal issues that can affect the boundaries of what is acceptable and what is unacceptable practice, especially when delivering health care to persons with beliefs different from their own. As the various cultures of the world merge together in communities, the education and training of caregivers become more complex. The caregiver must not only grasp the clinical skills of his or her profession but also have a basic understanding of what is right and what is wrong from both a legal and an ethical point of view. Although decision making is not always perfect, the knowledge gained from this text will aid the reader in making better decisions.

## PRINCIPLES OF ETHICS

*You cannot by tying an opinion to a man's tongue, make him the representative of that opinion; and at the close of any battle for principles, his name will be found neither among the dead, nor the wounded, but the missing.*

—E. P. Whipple (1819–1886)

*An army of principles can penetrate where an army of soldiers cannot.*

—Thomas Jefferson

*Ethical principles* are universal rules of conduct, derived from ethical theories that provide a practical basis for identifying what kinds of actions, intentions, and motives are valued. Ethical principles assist caregivers in making choices based on moral principles that have been identified as standards considered meaningful when addressing health care–related ethical dilemmas. As noted by the principles discussed in the following sections, caregivers, in the study of ethics, will find that difficult decisions often involve choices between conflicting ethical principles.

### Autonomy

*No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law.*

—*Union Pacific Ry. Co. v. Botsford* [141 U.S. 250, 251 (1891)]

The principle of *autonomy* involves recognizing the right of a person to make one's own decisions. "Auto" comes from a Greek word meaning "self" or the "individual." In this context, it means recognizing an individual's right to make his or her own decisions about what is best for him- or herself. Autonomy is not an absolute principle. The autonomous actions of one

person must not infringe upon the rights of another. The eminent Justice Benjamin Cardozo, in *Schloendorff v. Society of New York Hospital*, stated:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages, except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.[11]

Each person has a right to make his or her own decisions about health care. A patient has the right to refuse to receive health care even if it would be beneficial to saving his or her life. Respect for autonomy has been recognized in the Fourteenth Amendment to the Constitution of the United States. The law upholds an individual's right to make healthcare decisions. Patients can refuse treatment, refuse to take medications, and refuse invasive procedures regardless of the benefits that may be derived from them. They have a right to have their decisions adhered to by family members who may disagree simply because they are unable to let go. Although patients have a right to make their own choices, they also have a concomitant right to know the risks, benefits, and alternatives to recommended procedures.

Autonomous decision making can be affected by one's disabilities, mental status, maturity, or incapacity to make decisions. Although the principle of autonomy may be inapplicable in certain cases, one's autonomous wishes may be carried out through an advance directive and/or an appointed healthcare agent in the event of one's inability to make decisions.

What happens when the right to autonomy conflicts with other moral principles, such as beneficence and justice? Conflict can arise, for example, when a patient refuses a blood transfusion considered necessary to save his or her life whereas the caregiver's principal obligation is to do no harm. Determining the right thing to do in any given circumstance is not always an easy decision, as noted in the following **Reality Check** where the husband decides to withhold his wife's prognosis.

## REALITY Spouse's Grief Leads to Withholding the Truth

Annie, a 27-year-old woman with one child, began experiencing severe pain in her abdomen while visiting her family in May. After describing the excruciating pain to her husband, Daniel, he scheduled Annie for an appointment with Dr. Sokol, a gastroenterologist, who ordered a series of tests. While conducting a barium scan, a radiologist at Community Hospital noted a small bowel obstruction. Dr. Sokol recommended surgery, to which both Annie and Daniel agreed.

After the surgery, on July 7, Dr. Brown, the operating surgeon, paged Daniel over the hospital intercom as he walked down a corridor on the ground floor. Daniel, hearing the page, picked up a house phone and dialed zero for an operator. The operator inquired, "May I help you?" "Yes," Daniel replied. "I was just paged." The operator replied, "Oh, yes. Dr. Brown would like to talk to you. I will connect you with him. Hang on. Don't hang up." (Daniel's heart began to pound.) Dr. Brown asked, "Is this you, Daniel?" Daniel replied, "Yes, it is." Dr. Brown replied, "Well, surgery is over. Your wife is recovering nicely in the recovery room." Daniel was relieved, but only for a moment; he sensed Dr. Brown had more to say. Dr. Brown continued, "I am sorry to say that she has carcinoma of the colon." Daniel replied, "Did you get it all?" Dr. Brown reluctantly replied, "I am sorry, but the cancer has spread to her lymph nodes and surrounding organs." Daniel, with tears in his eyes, asked, "Can I see her?" Dr. Brown replied, "She is in the recovery room." Before hanging up, Daniel told Dr. Brown, "Please do not tell Annie that she has cancer. I want her to always have hope." Dr. Brown agreed, "Don't worry, I won't tell her. You can tell her that she had a narrowing of the colon."

Daniel hung up the phone and proceeded to the recovery room. After entering the recovery room, he spotted his wife. His heart sank. Tubes seemed to be running out of every part of her body. He walked to her bedside. His immediate concern was to see her wake up and have the tubes pulled out so that he could take her home.

Later, in a hospital room, Annie asked Daniel, "What did the doctor find?" Daniel replied, "He found a narrowing of the colon."

"Am I going to be okay?"

"Yes, but it will take a while to recover."

"Oh, that's good. I was so worried," said Annie. "You go home and get some rest."

Daniel said, "I'll be back later," as Annie fell back to sleep.

Daniel left the hospital and went to see his friends, Jerry and Helen, who had invited him for dinner. As Daniel pulled up to Jerry and Helen's home, he got out of his car and just stood there, looking up a long stairway leading to

*(continues)*

## REALITY Spouse's Grief Leads to Withholding the Truth *(continued)*

Jerry and Helen's home. They were standing there looking down at Daniel. It was early evening. The sun was setting. A warm breeze was blowing, and Helen's eyes were watering. Those few moments seemed like a lifetime. Daniel discovered a new emotion, as he stood there speechless. He knew then that he was losing a part of himself. Things would never be the same.

Annie had one more surgery 2 months later in a futile attempt to extend her life. In November 2002, Annie was admitted to the hospital for the last time. Annie was so ill that even during her last moments she was unaware that she was dying.

Dr. Brown entered the room and asked Daniel, "Can I see you for a few moments?"

"Yes," Daniel replied. He followed Dr. Brown into the hallway.

"Daniel, I can keep Annie alive for a few more days, or we can let her go." Daniel, not responding, went back into the room. He was now alone with Annie. Shortly thereafter, a nurse walked into the room and gave Annie an injection. Daniel asked, "What did you give her?" The nurse replied, "Something to make her more comfortable." Annie had been asleep; she awoke, looked at Daniel, and said, "Could you please cancel my appointment to be sworn in as a citizen? I will have to reschedule. I don't think I will be well enough to go."

Daniel replied, "Okay, try to get some rest." Annie closed her eyes, never to open them again.

***Discussion***

1. Do you agree with Daniel's decision not to tell Annie about the seriousness of her illness? Explain your answer.
2. Should the physician have spoken to Annie as to the seriousness of her illness regardless of Daniel's desire to give Annie hope and not a death sentence? Explain your answer.
3. Describe the ethical dilemmas in this case (e.g., how Annie's rights were violated).
4. Place yourself in Annie's shoes, the physician's shoes, and Daniel's shoes, and then discuss how the lives of each may have been different if the physician had informed Annie as to the seriousness of her illness.

This case raises numerous questions, often resulting in conflicts among ethics, the law, patient rights, and family wishes. From a professional ethics point of view, the American Medical Association provides in its *Principles of Medical Ethics* that:

> IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.[12]

Legally, pursuant to the Patient Self-Determination Act of 1990, patients have a right to make their own healthcare decisions, to accept or refuse medical treatment, and to execute an advance healthcare directive. Practically speaking, as discussion of this case illustrates, one size does not fit all. Both legal and ethical edicts have often served to raise an unending stream of questions that involve both the law and ethics. Although discussed later, a case here has been made for the need of a well-balanced ethics committee to help caregivers, patients, and family come to a consensus in the decision-making process.

### *Life or Death: The Right to Choose*

A Jehovah's Witness in *Stamford Hospital v. Vega*[13] executed a release requesting that no blood or its derivatives be administered during hospitalization. The Connecticut Superior Court determined that the hospital had no common law right or obligation to thrust unwanted medical care on the patient because she had been sufficiently informed of the consequences of the refusal to accept blood transfusions. She had competently and clearly declined that care. The hospital's interests were sufficiently protected by her informed choice, and neither it nor the trial court in this case was entitled to override that choice. "Thus, under the facts of this case, Vega's common law right of bodily self-determination was entitled to respect and protection. The trial court, therefore, improperly issued an injunction that permitted the hospital to administer blood transfusions to Vega."[14]

## Beneficence

*Beneficence* describes the principle of doing good, demonstrating kindness, showing compassion, and helping others. In the healthcare setting, caregivers demonstrate beneficence by providing benefits and balancing benefits against risks. Beneficence requires one to do good. Doing good requires knowledge of the beliefs, culture, values, and preferences of the patient—what one person may believe to be good for a patient may in reality be harmful. For example, a caregiver

may decide to tell a patient frankly, "There is nothing else that I can do for you." This could be injurious to the patient if the patient really wants encouragement and information about care options from the caregiver. Compassion here requires the caregiver to tell the patient, "I am not aware of new treatments for your illness; however, I have some ideas about how I can help treat your symptoms and make you more comfortable. In addition, I will keep you informed as to any significant research that may be helpful in treating your disease processes."

## Paternalism

*Paternalism* is a form of beneficence. People sometimes believe that they know what is best for another and make decisions that they believe are in that person's best interests. It may involve, for example, withholding information, believing that the person would be better off that way. Paternalism can occur because of one's age, cognitive ability, and level of dependency. A patient's rights to self-determination are compromised when a third party imposes their wishes upon those of another person.

**CPR and Paternalism in Nursing Homes** Some nursing homes have implemented no-CPR policies, as noted in the following Centers for Medicare and Medicaid Services Memorandum. Nursing home patients have a right to make their own care decisions. Having a policy of no resuscitation measures in the nursing home setting is a paternalistic approach to patient care that eliminates patients' option to make that decision for themselves—a clear violation of patients' rights and autonomous decision making. Such policies are unconditionally morally and legally wrong.

### Memorandum Summary

- **Initiation of CPR—**Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. CPR-certified staff must be available at all times.
- **Facility CPR Policy—**Some nursing homes have implemented facility-wide no-CPR policies. Facilities must not establish and implement facility-wide no-CPR policies.
- **Surveyor Implications—**Surveyors should ascertain that facility policies related to emergency response require staff to initiate CPR as appropriate and that records do not reflect instances where CPR was not initiated by staff even though the resident requested CPR or had not formulated advance directives.[15]

## Physicians and Paternalism

*Medical paternalism* often involves physicians unwittingly making decisions for patients who are capable of making their own choices. Physicians often find themselves in situations where they can influence a patient's healthcare decision simply by selectively telling the patient what he or she prefers based on personal beliefs. This directly violates patient autonomy. The problem of paternalism involves a conflict between the principles of autonomy and beneficence, each of which may be viewed and weighed differently, for example, by the physician and patient, physician and family member, or even the patient and a family member.

Paul Ramsey in *The Patient as Person* (1970) discusses the question of paternalism. As physicians are faced with many options for saving lives, transplanting organs, and furthering research, they also must wrestle with new and troubling choices—for example, who should receive scarce resources (e.g., organ transplants), determining when life ends, and what limits should be placed on care for the dying.

Dr. David S. Brody describes in the November 1980 issue of the *Annals of Internal Medicine* how physicians have traditionally played a paternalistic role in the delivery of patient care. He writes that physicians today must bear in mind the autonomous right of patients to participate in the decision-making process.

> Practicing physicians must frequently make decisions about how much they wish to encourage patient participation in clinical decision-making and how to respond to rational patient demands that do not coincide with their own decisions. These are difficult ethical dilemmas with no indisputable or universal solutions. The traditional concept of the doctor-patient relationship places the patient in a passive, compliant role. The patient's only obligation is to seek competent help and cooperate with the physician. A number of factors have contributed to the continued dominance of the traditional doctor-patient imbalance of power. Despite these factors, there seems to be a great deal of public dissatisfaction with health care delivery in the United States; demands for more patient autonomy are increasing.[16]

Ultimately, as determined by court decisions, it is the patient's right to know and choose what course of treatment they wish to pursue without undue pressure from the physician.

### *Employment-Related Paternalism*

*Employment-related paternalism* at its best is a shared and cooperative style of management in which the employer recognizes and considers employee rights when making decisions in the workplace. Paternalism at its worst occurs when the employer's style of management becomes more authoritarian, sometimes arbitrary, and unpredictable, as noted in the **Reality Check** presented next. In this scenario the employer has complete discretion in making workplace decisions and the individual employee's freedom is subordinate to the employer's authority. Here the employer requires strict obedience to follow orders without question. The supervisor in this case illustrated a lack of respect and consideration for the employee in a place remote from his office.

## REALITY *Paternalism and Breach of Confidentiality*

Nina traveled with her husband, Dan, to his work assignment at a hospital in Michigan so that she could visit her brother, who lived nearby. While visiting with her brother, Nina believed that her potassium was low—a frequent occurrence with her for many years. Nina's brother suggested she could have her blood tested at a local blood drawing station. Dan later learned Nina's potassium was low; he confided this to a colleague, a nurse named Joan, who'd asked how his wife was doing.

Later that morning, while at work, Joan called Bill, Dan's supervisor, to discuss Nina's health. Bill, however, had overslept and had not yet arrived at work. Joan decided to speak to the supervisor on call. After that conversation, Joan tracked Dan down on several occasions that morning by asking staff members his whereabouts. On the first occasion, at approximately 10:15 AM, Dan was surveying the organization's Oncology Infusion Center when Joan arrived. She called Dan aside, excusing the organization's staff from the immediate area, and said with surprise, "Dan, you are working?" Dan, even more surprised at the question, "Yes, I have been working." Joan replied, "Well, anyway, the corporate office wants to speak to you." Dan said he would call during lunch hour. Joan, somewhat agitated, walked away.

Joan again tracked Dan down once again with the help of the organization's staff at 11:30 AM. She located Dan while he was in the organization's transfusion center. She entered the conference room where Dan was discussing the care being rendered to a cancer patient. She said in a stern tone of voice, "Could everyone please leave the room. I need to talk to Dan." The organization's staff left the room, and Joan said, "I finally reached Bill and he wants you to call him." Dan inquired, "Is he pulling me off this assignment?" Joan replied, "Yes, he is. I spoke to Bill, and he has decided that out of concern for Nina, you should be removed from this particular assignment. He wants you to call him." Dan replied, "I don't understand why you did this—calling Bill, continually interrupting my work, and sharing confidential information about my wife with others. I will wrap up with the staff my review of this patient and call Bill." As Joan left the conference room, Dan added, "I trusted you, and you shared confidential information about my wife?" Joan, realizing that she had no right to share the information, quickly walked away.

Dan called Bill during his lunch break. During that call Bill said, "I am going to remove you from your assignment because I think your wife's health needs should be addressed, and this could be disruptive to the survey." Dan replied, "The only disruption has been the nurse tracking me down with staff from the organization and not conducting her work activities." Bill said, "My decision stands. You can opt to take vacation time for the remainder of the week."

#### *Discussion*

1. Discuss what examples of paternalism you have gleaned from this case.
2. Discuss the issues of trust, confidentiality, and fairness as they relate to this case.

At present, the federal employment discrimination laws fail to provide uniform and consistent legal protection when an employer engages in applicant-specific paternalism—the practice of excluding an applicant merely to protect that person from job-related safety and/or health risks uniquely attributable to his or her federally protected characteristic(s). Under Title VII of the Civil Rights Act of 1964, the courts and the Equal Employment Opportunity Commission (EEOC) reject such paternalism, demanding that the applicant alone decide whether to pursue (and accept) a job that poses risks related to his or her sex, race, color, religion, or national origin.[17]

# Case Studies

## Can a Physician "Change His or Her Mind"?

Bill Walls had a condition that caused his left eye to be out of alignment with his right eye. Walls discussed with Dr. Shreck, his physician, the possibility of surgery on his left eye to bring both eyes into alignment. Walls and Shreck agreed that the best approach to treating Walls was to attempt surgery on the left eye. Before surgery, Walls signed an authorization and consent form that included the following language:

- I hereby authorize Dr. Shreck . . . to perform the following procedure and/or alternative procedure necessary to treat my condition . . . of the left eye.
- I understand the reason for the procedure is to straighten my left eye to keep it from going to the left.
- It has been explained to me that conditions may arise during this procedure whereby a different procedure or an additional procedure may need to be performed, and I authorize my physician and his assistants to do what they feel is needed and necessary.

During surgery, Shreck encountered excessive scar tissue on the muscles of Walls's left eye and elected to adjust the muscles of the right eye instead. When Walls awoke from the anesthesia, he expressed anger at the fact that both of his eyes were bandaged. The next day, Walls went to Shreck's office for a follow-up visit and adjustment of his sutures. Walls asked Shreck why he had operated on the right eye, and Shreck responded that "he reserved the right to change his mind" during surgery.

Walls filed a lawsuit. The trial court concluded that Walls had failed to establish that Shreck had violated any standard of care. It sustained Shreck's motion for directed verdict, and Walls appealed. The court stated that the consent form that had been signed indicated that there can be extenuating circumstances when the surgeon exceeds the scope of what was discussed presurgery. Walls claimed that it was his impression that Shreck was talking about surgeries in general.

Dr. Roussel, an ophthalmologist, had testified on behalf of Walls. Roussel stated that it was customary to discuss with patients the potential risks of a surgery, benefits, and the alternatives to surgery. Roussel testified that medical ethics requires informed consent.

Dr. Shreck claimed that he had obtained the patient's informed consent not from the form but from what he discussed with the patient in his office. The court found that the form itself does not give or deny permission for anything. Rather, it is evidence of the discussions that occurred and during which informed consent was obtained. Shreck therefore asserted that he obtained informed consent to operate on both eyes based on his office discussions with Walls.

Ordinarily, in a medical malpractice case, the plaintiff must prove the physician's negligence by expert testimony. One of the exceptions to the requirement of expert testimony is the situation whereby the evidence and the circumstances are such that the recognition of the alleged negligence may be presumed to be within the comprehension of laypersons. This exception is referred to as the "common knowledge exception."

The evidence showed that Dr. Shreck did not discuss with Walls that surgery might be required on both eyes during the same operation. There was evidence that Walls specifically told Shreck he did not want surgery performed on the right eye.

Expert testimony was not required to establish that Walls did not give express or implied consent for Shreck to operate on his right eye. Absent an emergency, it is common knowledge that a reasonably prudent healthcare provider would not operate on part of a patient's body if the patient told the healthcare provider not to do so.

On appeal, the trial court was found to have erred in directing a verdict in favor of Shreck. The evidence presented established that the standard of care in similar communities requires healthcare providers to obtain informed consent before performing surgery. In this case, the applicable standard of care required Shreck to obtain Walls's express or implied consent to perform surgery on his right eye.

[*Walls v. Shreck*, 658 N.W.2d 686 (2003)]

### *Ethical and Legal Issues*

1. Discuss the conflicting ethical principles in this case.
2. Did the physician's actions in this case involve medical paternalism? Explain your answer.

### NEWS Abusing Assisted Suicide Laws

The debate surrounding legalizing assisted suicide is largely cast as one focusing on an individual who genuinely wants to end his or her life because of the pain and suffering they're experiencing due to a terminal medical condition. But this issue is wholly different—the possible cold-blooded and brutal abuse of those laws by bureaucrats in insurance companies against patients whom they determine are too expensive to keep alive.

And then there are the doctors. Healers who pledge to do no harm are now facing a system which will eventually expect them to do just that.

—Tammy Bruce, *The Washington Times*, June 7, 2017

## Nonmaleficence

*Nonmaleficence* is an ethical principle that requires caregivers to avoid causing patients harm. It derives from the ancient maxim *primum non nocere*, translated from the Latin, "first, do no harm." Physicians today still swear by the code of Hippocrates, pledging to do no harm. Medical ethics requires healthcare providers to "first, do no harm." A New Jersey court in *In re Conroy*[18] found that "the physician's primary obligation is . . . First do no harm." Telling the truth, for example, can sometimes cause harm. If there is no cure for a patient's disease, you may have a dilemma. Do I tell the patient and possibly cause serious psychological harm, or do I give the patient what I consider to be false hopes? Is there a middle ground? If so, what is it? To avoid causing harm, alternatives may need to be considered in solving the ethical dilemma.

The caregiver, realizing that he or she cannot help a particular patient, attempts to avoid harming the patient. This is done as a caution against taking a serious risk with the patient or doing something that has no immediate or long-term benefits.

### *Law and Ethics Intersect*

### NEWS Peninsula Child Psychiatrist William Ayres Sentenced to Eight Years for Molesting Patients

REDWOOD CITY—As one victim after another testified, calling William Ayres a monster and a serial child-abuser who robbed them of their innocence, the once-renowned child psychiatrist sat stoically Monday as a judge sentenced him to eight years in prison for molesting his former patients.

Ayres used his work with boys having trouble at school, at home or with the law as a setting to abuse them, the victims said. His position of authority allowed him to deflect suspicions about his sexual interest in boys and keep parents from believing their sons' complaints, victims said.

—Joshua Melvin, *San Jose Mercury News*, August 27, 2013[19]

The patients described in the news clippings were harmed because the physician who was trained to do good did wrong by taking advantage of the patients' weaknesses. The beneficent person does good and not harm (nonmaleficence). The law in the news clipping is clear. If a person with intent and action causes harm to the patient, that person will be punished.

One of the many lessons in the next **Reality Check** teaches the reader that one may have good intent, but that intent can lead to a perceived wrong and thus be damaging to one's good character and possibly one's career path.

### REALITY Patient Questions Physical Exam

Dear Sir:

I was a patient on your short-term acute-care psychiatric unit. It was a voluntary admission, as is the case with all patients on that unit. Dr. X was my psychiatrist. Although he was very good as a psychiatrist, I was somewhat disturbed in the way he conducted my physical examination. He had come to my room on the day of my admission and said that he needed to perform a physical exam. He had already conducted a thorough history of my physical ailments and thoroughly reviewed my family history as far back as I could remember.

We were in the room alone when he entered. He had a gown in his hand and asked me to put it on. He walked out of the room and said he would be back in a few minutes. When he returned, he began to conduct a physical examination. Early on in the exam, he asked when I had my last breast examination. I told him that I was 28 and never had one. He said, "Well, I'd better do one." I thought it was a bit odd that he conducted the exam without a female nurse

present. I became more concerned when he touched my breasts in what I considered a sensual manner. It was uncanny. It seemed to be a bit more than what I would've expected during a breast examination. He seemed to be caressing my breasts, as opposed to examining them. I don't know if this is a routine procedure, but I was very uncomfortable in the situation. I think it would be better if you considered having a female nurse present when conducting female examinations in a patient room on a psychiatric unit or on any other unit for that matter.

Thanks for listening to my concerns.

—Anonymous

***Administrator***

I called Dr. X into my office and discussed the patient's concerns with him. He said this is what physicians are trained to do. "We are trained to conduct both history and physical examinations." He had brought with him a letter from one of his professional associations that stated psychiatrists are permitted to perform physical examinations on their patients. I asked him why he did not have someone in the room with him when he examined the patient. He stated, "I generally do, but I was extremely busy, and the staff was swamped with other patients. It was just a hectic day."

***Discussion***

Discuss how you would respond to the patient.

1. Describe how you would resolve this issue with the physician, assuming this was the first complaint that you had received regarding his care.
2. Explain what policy decisions you would implement.
3. Knowing that the physician is in a position of trust with his patient, discuss what action the physician should take to prevent complaints of this nature from recurring.

The intersection of "law" and "ethics" is clear. Deviation from either can lead to unsatisfactory outcomes for both physicians and patients. Although a caregiver may be trained to conduct a physical examination, the question may not be "can I do it?" but "should I do it?"

### *Tuskegee Syphilis Experiment*

The Tuskegee syphilis experiment, conducted by the U.S. Public Health Service between 1932 and 1972, was designed to analyze the natural progression of untreated syphilis in African American men. The participants were not warned during the study that penicillin was available as the cure for syphilis. They believed that they were receiving adequate care and unknowingly suffered unnecessarily. The Tuskegee syphilis study used disadvantaged, rural black men to investigate the untreated course of the disease, one that is by no means confined to that population. The study should have recognized from the beginning that selection of research subjects, regardless of race, must be closely monitored to ensure that specific classes of individuals (e.g., terminally ill patients, welfare patients, racial and ethnic minorities, or persons confined to institutions) are not selected for research studies based on their availability, compromised position, or manipulability. Rather, they must be selected for reasons directly related to the research being conducted. The ethical principle of *nonmaleficence* requires all people to avoid causing harm. In this case, the failure to alert those involved in the research study that a cure was available was both ethically and legally wrong.

### *Nonmaleficence and Ending Life*

The principle of nonmaleficence is defeated when a physician is placed in the position of ending life by removing respirators, giving lethal injections, or writing prescriptions for lethal doses of medication. Helping patients die violates the physician's duty to save lives. In the final analysis, there needs to be a distinction between killing patients and letting them die. It is clear that killing a patient is never justified.

## Justice

*Justice* is the obligation to be fair in the distribution of benefits and risks. Justice demands that persons in similar circumstances be treated similarly. A person is treated justly when he or she receives what is due, is deserved, or can legitimately be claimed. Justice involves how people are treated when their interests compete with one another.

*Distributive justice* is a principle requiring that all persons be treated equally and fairly. No one person, for example, should get a disproportional share of society's resources or benefits. There are many ethical issues involved in the rationing of health care. This is often a result of limited or scarce resources,

limited access as a result of geographic remoteness, or a patient's inability to pay for services combined with some physicians unwilling to accept patients who are perceived as "no-pays" with high risks for legal suits.

Senator Edward M. Kennedy, speaking on health care at the John F. Kennedy Presidential Library in Boston, Massachusetts, on April 28, 2002, stated:

> It will be no surprise to this audience that I believe securing quality, affordable health insurance for every American is a matter of simple justice. Health care is not just another commodity. Good health is not a gift to be rationed based on ability to pay. The time is long overdue for America to join the rest of the industrialized world in recognizing this fundamental need.[20]

Later, speaking at the Democratic National Convention on August 25, 2008, Kennedy said:

> And this is the cause of my life—new hope that we will break the old gridlock and guarantee that every American—North, South, East, West, young, old—will have decent, quality health care as a fundamental right and not a privilege.[21]

Although Senator Kennedy did not live to see the day his dream would come true, President Barack Obama signed into law the final piece of his administration's historic healthcare bill on March 23, 2010. The law, however, has yet to provide the coverage as described by the late Senator Kennedy and remains a political football in Congress.

The costs of health care have bankrupted many, and research dollars have proven to be inadequate, yet many members of Congress elected to address the needs of the country have chosen to continue their bipartisan bickering while they "enjoy" the lowest acceptance ratings in the nation's history. They have, however, ensured that their own healthcare needs are met with the best of care in the best facilities with the best doctors. They have taken care of themselves. Their pensions are intact, whereas many Americans have to face such dilemmas as which medications they will take and which they cannot afford. Many Americans often have to decide between food and medications, with life-and-death consequences. Is this justice or theft of the nation's resources by the few incompetents who have been elected to protect the American people? Unfortunately, these problems continue to this day as Congress continues to wrangle over national health insurance.

### *Justice and Government Spending*

#### NEWS *He Won His Battle With Cancer. Why Are Millions of Americans Still Losing Theirs?*

For an increasing number of cancer activists, researchers, and patients, there is too much death and too much waiting for new drugs and therapies. They want a greater sense of urgency, a new approach that emphasizes translational research over basic research—turning knowledge into therapies and getting them to patients pronto. The problem is, that's not the way our sclerotic research paradigm—principally administered by the National Institutes of Health and the National Cancer Institute (NIH/NCI)—is set up. "The fact that we jump up and down when cancer deaths go from 562,000 to 561,000, that's ridiculous. That's not enough," says Lance Armstrong, the cyclist and cancer survivor turned activist, through his Lance Armstrong Foundation (LAF).

—*Time*, September 15, 2008

Limited financial resources are challenging to the principles of justice. Justice involves equality; nevertheless, equal access to health care is at best a hope, a dream, and a promise to which all are committed on both sides of the political spectrum. A pathway to achieving this goal remains controversial. With total U.S. health spending costing over $10,000 per person,[22,23] how should healthcare dollars be allocated between healthcare education, preventative care, healthcare insurance programs (e.g., Medicare, Medicaid, Indian Health Services, TRICARE, Veterans Health Administration) for curative care, rehabilitation programs, long-term care, and research. [Note: There is no accurate, foolproof way to know what people spend on health care. For example, added unknown costs include over-the-counter drugs, questionable health supplements and vitamins, among many other expenses that are difficult to track, such as travel and transportation to a practitioner or healthcare facility.] The "U.S. federal budget deficit for fiscal year 2019 is $985 billion. FY 2019 covers October 1, 2018 through September 30, 2019. The deficit occurs because the U.S. government spending of $4.407 trillion is higher than its revenue of $3.422 trillion."[24] Considering the scarcity of resources for healthcare expenditures, who and what should the parameters be as to how to allocate scarce financial resources? If the parameter sets merely short-term objectives to maximize the health

benefits for the population served, some will receive a higher quality of care while others will receive, at best, satisfactory care. With an aging population, long-term care will require more funding, thus competing for dollars with education and prevention, which are the driving forces to ensure a healthier lifestyle. It will also compete with the research funding that over the long term will lead to lower costs of care associated with debilitating diseases that accompany the aging process. Education and prevention will improve the quality of life, as well as life expectancy, thus they more effectively address the quality of life for future generations. The funding allocation challenge remains as to how this generation will prioritize the need for a healthier lifestyle and allowing for improved funding for research activities that extends the quality of life. Justice in the distribution of limited dollars often results in fewer dollars for so-called orphan diseases (e.g., scleroderma, lupus), which are underfunded because they affect fewer people. Thus, the lion's share of dollars continues to be directed toward research on diseases that affect the greater proportion of the population, leaving less for research on less widespread conditions.

There are many variables to take into consideration when determining how to distribute limited funds that will equally benefit all when there are other variables that must be considered that affect the quality of a healthy society. The obligation to be just and fair in the distribution of scarce resources is not an easy pathway to follow when there are so many competing interests in an ever-changing world. It would be easy to allocate funds if the formula for total *unfailing quality patient care* would be: a + b + c = d (where a = unlimited resources for equipment, b = unlimited number of caregivers, c = sufficient facilities, and d = unfailing quality patient care). The formula for improving the health of the people may be much more complicated and written, with tongue in cheek, as: $a^x + b^y + c^z + c^z - b^y - a \log a (c^z - b^y) = d$. To better understand the complexity of the first formula requires understanding that the factors necessary to deliver high-quality care are ever-expanding; for example:

- It is not enough to merely have equipment; it must be high-quality equipment that improves patient outcomes.
- It is not enough to have merely the "right" number of persons on staff; the individual staff members must also be competent enough to perform the assigned tasks.
- It is not enough to have health facilities; they must be high-quality facilities.

Improving the health and well-being of the people is a moral concern. The careless allocation of scarce resources that are not cost-effective produces fewer benefits than would have been possible through the thoughtful and wise distribution of scarce resources. Because resources are limited, the allocation of funding must be equitable and just. Justice requires the fair distribution of limited funds, which is associated with the moral theories of *utilitarianism* and *consequentialism*.

Utilitarianism's starting point is that we all attempt to seek happiness and avoid pain, and therefore our moral focus ought to center on maximizing happiness (or, human flourishing generally) and minimizing pain for the greatest number of people. This is both about what our goals should be and how to achieve them. Consequentialism asserts that determining the greatest good for the greatest number of people (the utilitarian goal) is a matter of measuring outcome, and so decisions about what is moral should depend on the potential or realized costs and benefits of a moral belief or action. This is largely about determining how to attain our goals, which are taken to be self-evident.[25]

In summary, the allocation of limited resources requires the appropriate distribution of funds that address the promotion of healthy lifestyles, improvement in education and training programs, building state-of-the-art safe healthcare facilities equipped with the latest medical equipment, research, and translational medicine.

## REALITY States Have Double Standards

It is no secret that states have had double standards over the years—one for healthcare organizations and one for physicians and investors, who often duplicated the financially more lucrative hospital services while referring Medicaid patients and no-pays to hospital programs for care. As administrator of one hospital, allow me to give you a few examples:

1. A radiology group was able to purchase their own computed tomography (CT) scanner, while the hospital had to jump through hoops to be able to purchase one for the hospital.

*(continues)*

## REALITY States Have Double Standards *(continued)*

2. A group of surgeons and private investors established an ambulatory surgery center in direct competition with the hospital without scrutiny. At the same time, the hospital was required to justify the hospital's proposed surgery center. The hospital was required to complete lengthy questionnaires and gather supporting documentation to justify construction and operation of an outpatient surgery center.
3. The hospital had to justify opening an outpatient rehabilitation program within the hospital in order to provide a continuum of care for patients needing physical therapy services. While hospital staff was busy justifying the need for an outpatient rehabilitation program, orthopedic surgeons were busy setting up their own outpatient programs to compete with the hospital.

I remember walking to my car one day after work and one of my orthopedic surgeons caught up to me and said, "You know, Dan, I have made enough money in the 3 years that I have been on your staff to buy your hospital."

### *Discussion*

1. Discuss the issues of justice as they apply to this scenario.
2. Discuss the issues of fairness and how physician competition with hospitals can affect the quality of patient care.

## *Injustice for the Insured*

*Even if you're insured, getting ill could bankrupt you. Hospitals are garnishing wages, putting liens on homes and having patients who can't pay arrested. It's enough to make you sick.*

—Sara Austin[26]

Hospitals are receiving between $4 million and $60 million annually in charity funds in New York City alone, according to Elizabeth Benjamin, director of the health law unit of the Legal Aid Society of New York City; however, even the insured face injustice. In 2003, almost 1 million Americans declared bankruptcy because of medical issues, accounting for nearly half of all of the bankruptcies in the country. In 2016, a Kaiser Family Foundation poll found that nearly as many were declaring bankruptcy or struggling to pay medical bills despite expansion of affordable health insurance under the Affordable Care Act.[27]

When an insured patient gets ill and exhausts his or her insurance benefits, should the hospital be able to:

- Withhold the money from the patient's wages?
- Place a lien on the patient's home?
- Arrest the patient?
- Block the patient from applying for the hundreds of millions of dollars in government funds designated to help pay for care for those who need it?

According to an article that appeared in the *Journal of the American Medical Association* entitled "Medical Bankruptcy in the United States, 2007: Results of a National Study," "The US health care financing system is broken, and not only for the poor and uninsured. Middle-class families frequently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones."[28]

Not only are patients facing financial crisis and/or going bankrupt, hospitals are facing the same fate. As of September 2017, hospital bankruptcies totaled 22. Ayla Ellison, author of "22 Bankruptcies So Far in 2017," writes in her article: "From reimbursement landscape challenges to dwindling patient volumes, many factors lead hospitals and other healthcare organizations to file for bankruptcy."[29]

## *Age and Justice*

## NEWS New Kidney Transplant Rules Would Favor Younger Patients

The nation's organ transplant network is considering giving younger, healthier people preference over older, sicker patients for the best kidneys.

Some also complain that the new system would unfairly penalize middle-aged and elderly patients at a time when the overall population is getting older.

If adopted, the approach could have implications for other decisions about how to allocate scarce resources, such as expensive cancer drugs and ventilators during hurricanes and other emergencies. . . .

—Rob Stein, *The Washington Post*, February 24, 2011

- Should an 89-year-old patient get a heart transplant, rather than a 10-year-old girl, just because he or she is higher on the waiting list?
- Should a 39-year-old single patient, rather than a 10-year-old boy, get a heart transplant because he or she is higher on the waiting list?
- Should a 29-year-old mother of three get a heart transplant, rather than a 10-year-old girl, because she is higher on the waiting list?
- Should a 29-year-old pregnant mother with two children, rather than a 10-year-old boy, get a heart transplant because she is higher on the waiting list?

### Justice and Emergency Care

When two patients arrive in the emergency department in critical condition, consider who should receive treatment first. Should the caregiver base his or her decision on the:

- First patient who walks through the door?
- Age of the patients?
- Likelihood of survival?
- Ability of the patient to pay for services rendered?
- Condition of the patient?

Patients are to be treated justly, fairly, and equally. What happens, however, when resources are scarce and only one patient can be treated at a time? What happens if caregivers decide that age should be the determining factor as to who is treated first? One patient is saved, and another dies. What happens if the patient saved is terminal and has an advance directive in his wallet requesting no heroic measures to save his life? What are the legal issues intertwined with the ethical issues in this case?

The principle of distributive justice raises numerous issues, including how limited resources should be allocated. For example, when there is a reduction in staff in healthcare organizations, managers are generally asked to eliminate "nonessential" personnel. In the healthcare industry, this translates to those individuals not directly involved in patient care (e.g., maintenance and housekeeping employees). Is this fair? Is this just? Is this the right thing to do?

### In Search of Economic Justice

In 2008, Avery Comarow, in his article "Under the Knife in Bangalore,"[30] wrote that the high cost of U.S. hospital care is motivating patients to travel to places like India and Thailand for major procedures. A decade later, not much has changed: A 2016 article estimated 1.4 million Americans would travel overseas to obtain less expensive healthcare services.[31] There would be no need for uninsured patients to go abroad if the prices they were quoted in the United States were more in line with what insurers and Medicare pay. The uninsured often pay full price for medical procedures in the United States. For example, a self-pay patient will pay between $70,000 and $133,000 for coronary bypass surgery, whereas Medicare will pay between $18,609 and $23,589. Commercial insurance plans often get up to a 60% discount off the list cost of medical procedures. In India, the same surgery will cost the patient $7,000, and in Thailand, it will be $22,000.

To avoid bankruptcy and loss of assets, maybe their homes, Americans risk the unknowns of going abroad for health care.

### REALITY Boomer Bubble "Bioeconomics"

As baby boomers become Medicare eligible, there is likely to be a huge strain on the federal budget. Is this dramatically increased cost justified, beneficial, and necessary to the country as a whole?

The revenue from working, taxpaying baby boomers over the past four decades has fueled unprecedented prosperity. That revenue has made many entitlements possible, but it is going to diminish drastically as boomers retire and become recipients instead of contributors to the revenue base. Advances in medical technology have increased longevity dramatically, and boomers therefore are likely to be on the receiving end of entitlements for a long time. Medical advances, however, also can increase productivity as well as longevity. Boomers with a lifetime of work experience can be a valuable resource if they are kept healthy enough to remain gainfully employed at some level. Maintenance of a skilled American workforce is essential for future prosperity and economic stability. Boomers are a substantial resource of experienced skilled workers. It is a political necessity that they are encouraged to stay productive. The government's subsidizing health care through Medicare and other programs is therefore an investment that can facilitate this worthwhile goal. Additional incentives may even be appropriate. Even on an ethical basis, boomers that fueled our economy for so long deserve to be taken care of in their later years. Hopefully, many of them will be healthy enough and willing enough to continue being productive beyond the usual retirement age. Thus, from a political perspective, the moral and ethical choice may also turn out to be the profitable choice for the people.

—Physician

## VIRTUE ETHICS AND VALUES

*Virtue ethics* focuses on the inherent character of a person rather than on the specific actions he or she performs. A *virtue* is a positive trait of moral excellence. Virtues are those characteristics that differentiate good people from bad people. Virtues such as courage, honesty, and justice are abstract moral principles. A morally virtuous person is one who does the good and right thing by habit, not merely based on a set of rules of conduct. The character of a virtuous person is naturally good, as exhibited by his or her unswerving good behavior and actions.

### REALITY *Resilience of the Health Caregiver Spirit*

I've been in leadership roles for two sister hospitals in southeast Louisiana, with each experiencing the devastation of hurricane damage twice in the past 3 years. The first experience was temporarily suspending normal operations in New Orleans, and recently, history repeated itself at the sister hospital in Houma, Louisiana.

In both instances, I was stunned at the determination and strength of healthcare teams to rebuild. Both hospitals needed to resort to MASH-type tent hospitals to allow rebuilding of the hospitals. Health care for the communities was not interrupted. Back-to-basics care ensued, but not without close attention to needed regulatory compliance standards. The regulatory agencies were called and involved from the get-go, and the caregiver teams and support service staff flourished with enthusiasm to survive and care for the patients in need. Was this because of the nonprofit nature of our state-sponsored hospitals? I don't think so. The human spirit takes over when it comes to patient care, no matter what.

I am happy to say that both New Orleans and Houma are back on track, with care being provided in top-quality hospitals. This is only due to the diligence of all, including facilities management, housekeeping, and multiple direct and indirect caregiver departments. What is the ethical issue here? There is no issue. Support for the art of caregiving will never be disappointed—at least not in southeast Louisiana. I stand in awe of what I have seen and look forward to growing with this team of devoted professionals.

—Nurse

*Values* are standards of conduct. They are used for judging the goodness or badness of some action. A *moral value* is the relative worth placed on some virtuous behavior. Values are rooted in customs and habits of a culture because the words *moral* and *ethics* themselves were essentially created to describe these topics: "The acquisition of culture begins at birth and continues throughout the life span."[32]

Values are the standards by which we measure the goodness in our lives. *Intrinsic value* is something that has value in and of itself (e.g., happiness). *Instrumental value* is something that helps to give value to something else (e.g., money is valuable for what it can buy).

Values may change as needs change. If one's basic needs for food, water, clothing, and housing have not been met, one's values may change such that a friendship, for example, might be sacrificed if one's basic needs can be better met as a result of the sacrifice. As a mother nears the end of her life, a financially well-off family member may want to take more aggressive measures to keep Mom alive despite the financial drain on her estate. Another family member, who is struggling financially, may more readily see the futility of expensive medical care and find it easier to let go. Values give purpose to each life. They make up one's moral character.

All people make value judgments and make choices among alternatives. Values are the motivating power of a person's actions and necessary to survival, both psychologically and physically.

The relationship between abstract virtues (principles) and values (practice) is often difficult to grasp. The virtuous person is one who does good, and his or her character is known through the values he or she practices consistently by habit.

We begin our discussion here with an overview of those virtues commonly accepted as having value when addressing difficult healthcare dilemmas. The reader should not get overly caught up in the philosophical morass of how virtues and values differ but should be aware that the words "virtues" and "values" have been used interchangeably. This text is not about memorizing words; it is about applying what we learn for the good of all whose lives we touch.

Whether we call compassion a virtue or a value or both, the importance for our purposes in this text is to understand what compassion is and how it is applied in the healthcare setting.

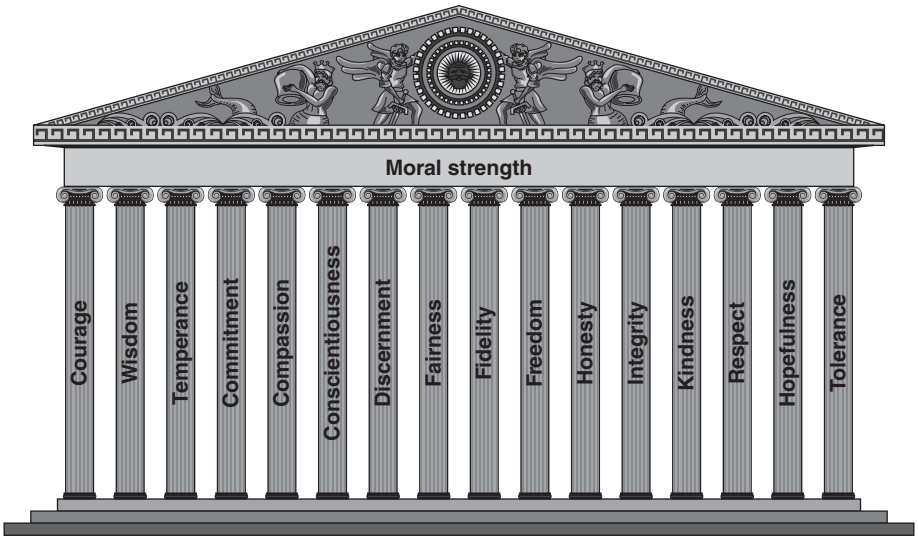


**FIGURE 1-1** Pillars of Moral Strength.

### *Pillars of Moral Strength*

*I am part of all I have met.*

—Alfred Tennyson

There is a deluge of ethical issues in every aspect of human existence. Although cultural differences, politics, and religion influence who we are, it is all of our life experiences that affect who we have become. If we have courage to do right, those who have influenced our lives were most likely courageous. If we are compassionate, it is most likely because we have been influenced by the compassionate.

The *Pillars of Moral Strength* illustrated in **FIGURE 1-1** describes a virtuous person. What is it that sets each person apart? In the final analysis, it is one's virtues and values that build moral character. Look beyond the words and ask, "Do I know their meanings?" "Do I apply their concepts?" "Do I know their value?" "Are they part of me?"

## Courage as a Virtue

*Courage is the greatest of all virtues, because if you haven't courage, you may not have an opportunity to use any of the others.*

—Samuel Johnson

*Courage* is the mental or moral strength to persevere and withstand danger. Courage can be characterized as the ladder upon which all the other virtues mount. Courage is the strength of character necessary to continue in the face of fears and the challenges in life. It involves balancing fear, self-confidence, and values. Without courage, we are unable to take the risks necessary to achieve the things most valued. A courageous person has good judgment and a clear sense of his or her strengths, correctly evaluates danger, and perseveres until a decision is made and the right goal that is being sought has been achieved. The **Reality Check** below describes the courage of a young lady facing a difficult journey in her battle with cancer.

### REALITY *My Journey—How Lucky Am I?*

No words can be scripted to say what I have been through, so I will just speak from my heart and off the cuff. From the day the doctor said to me, "Denise, you have a rare cancer and we are sorry there is nothing we can do," I did not waver in my faith in God. He was in me, he was through me and he was around me. I just asked the doctor, "What do I do?" And yet, although he said a whole bunch of words, I wasn't focused so much on what was being said. It's like a calmness was over me, not much worry, just a feeling of, *I will never be alone on this new journey I'm about to experience*. I felt calm. Not until I looked at my loved ones' faces did I realize, *oh my, this can be bad*. But again, a feeling came over me that I will not face this ALONE. God has plans for me and I will surrender in his grace and as time past [*sic*], I realized how lucky and blessed I am, for most people who may feel that death may be close by, I didn't feel that way. What I felt was WOW!! Everyone gets to show me their love in the NOW and not in the later when I am no longer here. How lucky am I?

—Denise

Courage, in differing degrees, helps to define one's character (the essence of one's being) and offers the strength to stand up for what is good and right. It crosses over and unites and affects all other values. Courage must not be exercised to an extreme, causing a person to become so foolish that his or her actions are later regretted.

When the passion to destroy another human being becomes such an obsession that one is willing to sacrifice the lives of others, that person has become a bully and a coward and not a person of courage. History is filled with men and women who have hidden their fears by inciting others to do evil. Such people are not the role models that we want our children to look to for character.

## Wisdom as a Virtue

*True wisdom comes to each of us when we realize how little we understand about life, ourselves, and the world around us.*

—Socrates

*We can learn from history how past generations thought and acted, how they responded to the demands of their time and how they solved their problems. We can learn by analogy, not by example, for our circumstances will always be different than theirs were. The main thing history can teach us is that human actions have consequences and that certain choices, once made, cannot be undone. They foreclose the possibility of making other choices and thus they determine future events.*

—Gerda Lerner (pioneer of women's history)

Wisdom is the judicious application of knowledge. Wisdom begins first by learning from the failures and successes of those who have preceded us. Marcus Tullius Cicero (106–43 BC), a Roman philosopher and politician, is reported to have said, "The function of wisdom is to discriminate between good and evil." In the healthcare setting, when the patient's wishes and end-of-life preferences are unknown, wisdom with good judgment without bias or prejudice springs forth more easily.

## Temperance as a Virtue

*Being forced to work, and forced to do your best, will breed in you temperance and self-control, diligence and strength of will, cheerfulness and content, and a hundred virtues which the idle will never know.*

—Charles Kingsley

Temperance involves self-control and restraint. It embraces moderation in thoughts and actions. Temperance is evidenced by orderliness and moderation in everything one says and does. It involves the ability to control one's actions so as not to go to extremes. The question arises, without the ability to control oneself from substance abuse, for example, how can a person possibly live the life of a virtuous person. The old adage, "the proof is in the pudding" lies in one's actions. A virtuous person stands out from the crowd by actions and deeds.

## Commitment

*Unless commitment is made, there are only promises and hopes, but no plans.*

—Peter F. Drucker

*I know the price of success: dedication, hard work, and an unremitting devotion to the things you want to see happen.*

—Frank Lloyd Wright

*Commitment* is the act of binding oneself intellectually and/or emotionally to a course of action (e.g., pursue a career, adhere to a religious belief) or person (e.g., marriage, family, patient care). It is an agreement or pledge to do something. It can be ongoing, such as in a marriage, or a pledge to do something in the future, such as an engagement as a commitment to marry a particular person.

## Compassion and Empathy

*Compassion is the basis of morality.*

—Arthur Schopenhauer

*Compassion* is the profound awareness of and sympathy for another's suffering. The ability to show compassion is a true mark of moral character. Compassion is a moral value expected of all caregivers. There are those who argue that compassion will blur one's judgment. Caregivers need to show the same compassion for others as they would expect for themselves or their loved ones. A person with compassion recognizes that someone is in pain (emotional, physical, or both) and tries his best to alleviate it.

Those who lack compassion have a weakness in their moral character. In 1996, Dr. Linda Peeno, featured in Michael Moore's 2007 film *Sicko*, testified before Congress to discuss her prior work for Humana, where she worked as a claims reviewer for several health maintenance organizations (HMOs). Dr. Peeno showed compassion as she testified before the Committee on Commerce on May 30, 1996. Here is her story in part:

> I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or

public forum. In fact, just the opposite occurred. I was rewarded for this. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was asked, expected of me, I exemplified the good company employee. I saved one half million dollars.

Since that day, I have lived with this act and many others eating into my heart and soul. The primary ethical norm is do no harm. I did worse, I caused death. Instead of using a clumsy bloody weapon, I used the simplest, cleanest of tools: my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for the moment. When any moral qualms arose, I was to remember, "I am not denying care; I am only denying payment."[33]

Duty-based ethics required Dr. Peeno to follow the rules of her job. In so doing, a life was lost. Although Dr. Peeno eventually came forward with her story, the irony here lies in the fact that Dr. Peeno lacked the courage, integrity, and compassion to report her story sooner. The lack of compassion for others plagues the healthcare industry in a variety of settings.

The stream of news clippings that illustrate the ongoing need for compassionate caregivers is presented here. The first clipping describes an incident where two nurses and an aide were indicted in the death of an elderly World War II veteran in an Atlanta, Georgia, nursing home. The three staff members were caught on camera laughing as the man gasped for air and pleaded for help.[34]

### NEWS WWII Veteran Calls for Help and Dies as Nurses Laugh, Video Shows

A hidden video from 2014 showed nurses laughing as a World War II veteran repeatedly called for help and died while in their care.

The family of James Dempsey, 89, of Woodstock, Ga., hid a camera in the late veteran's room in the Northeast Atlanta Health and Rehabilitation Center which captured the night he died.

The video showed the decorated WWII veteran repeatedly calling for help, saying he could not breathe. It also showed the nurses failing to take life-saving measures and laughing as they tried to start an oxygen machine.

—Fox News, November 18, 2017[35]

Lack of compassion is illustrated in another news report where a video showed a woman dying on the floor in a psychiatric facility.

### NEWS Hospital Video Shows no One Helped Dying Woman

A woman died on the floor in the psych ward at Kings County Hospital, while people around her, including a security guard, did nothing to help. After an hour, another mental patient finally got the attention of the indifferent hospital workers, according to the tape obtained by the *New York Daily News*.

Worse still, the surveillance tape suggests hospital staff may have falsified medical charts to cover the utter lack of treatment provided to Esmin Green before she died.

—John Marzulli, *New York Daily News*, June 30, 2008

A second egregious example that illustrates the lack of compassion was illustrated when a man expired while the ambulance crew attempted to find a hospital that would accept him for care.

### NEWS Elderly Patient Hit by Motorcycle Dies in Japan After Being Rejected by 14 Hospitals

After getting struck by a motorcycle, an elderly Japanese man with head injuries waited in an ambulance as paramedics phoned 14 hospitals, each refusing to treat him.

He died 90 minutes later at the facility that finally relented—one of thousands of victims repeatedly turned away in recent years by understaffed and overcrowded hospitals in Japan.

—Maria Yamaguchi, *Associated Press*, February 5, 2009

### NEWS Teaching Doctors to Care

At Harvard and other medical schools across the country, educators are beginning to realize that empathy is as valuable to a doctor as any clinical skill . . . doctors who try to understand their patients may be the best antidote for the widespread dissatisfaction with today's healthcare system.

—Nathan Thornburgh[36]

Empathy is a visceral feeling where a person sees another in pain and can place themselves in their shoes and feel that pain. According to Webster's dictionary, empathy is "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner."[37]

*Nothing is more important than empathy for another human being's suffering.*

*Nothing. Not a career, not wealth, not intelligence, certainly not status.*

*We have to feel for one another if we're going to survive with dignity.*

—Audrey Hepburn

Jodi Halpern, in her article "Empathy and Patient–Physician Conflicts," writes in the *Journal of General Internal Medicine* how physicians can *foster empathy during conflict*:

> Physicians associate empathy with benevolent emotions and with developing a shared understanding with patients. While there have been many articles on managing "difficult" patients, little attention has been paid to the challenges physicians face during conflicts with patients, especially when both parties are angry and yet empathy is still needed. This topic is especially important in light of recent studies showing that practicing medicine increasingly requires physicians to manage their own feelings of anger and frustration. This article seeks to describe how physicians can learn to empathize with patients even when they are both subject to emotions that lead to interpersonal distancing. Empathy is defined as engaged curiosity about another's particular emotional perspective. Five specific ways for physicians to foster empathy during conflict are described: recognizing one's own emotions, attending to negative emotions over time, attuning to patients' verbal and nonverbal emotional messages, and becoming receptive to negative feedback. Importantly, physicians who learn to empathize with patients during emotionally charged interactions can reduce anger and frustration and also increase their therapeutic impact.[38]

### NEWS The Fear Factor and Patient Satisfaction

Nurses tend to score highly on measures of empathy, care, and compassion. . . . Here is some specific advice about what hospitals can do to help nurses improve at calming their patients' fears.

- Encourage nurses to be sensitive to the level of fear their patients experience when they're admitted to the hospital. Empathy and communication are key . . .
- Set nurses up for success through training and support. In many instances, it is easy to deal with safety concerns by providing detailed protocols, policies, and procedures . . .

—Rick Blizzard, D.B.A.[39]

Tony Padilla writes with vision in his article entitled "Kindness: At the Center of Patient Experience Strategies," where he states:

> With its vision of "healing human kind, one patient at a time, by improving health, alleviating suffering, and delivering acts of kindness," UCLA Health has fulfilled the commitment to kindness by improving care delivery systems with patient experience and quality foremost in mind. In addition, as we have learned, when patient-centered communications become the norm, employees follow suit.
>
> Kindness truly is the foundation of any cultural transformation aimed at improving the patient experience.[40]

## Detachment

*Detachment*, or lack of concern for the patient's needs, often translates into mistakes that result in patient injuries. Those who have excessive emotional involvement in a patient's care may be best suited to work in those settings where patients are most likely to recover and have good outcomes (e.g., maternity units). As with all things in life, there needs to be a comfortable balance between compassion and detachment.

*Never apologize for showing feeling. When you do so, you apologize for the truth.*

—Benjamin Disraeli

## REALITY Policy Ruled—Compassion Missing

Mr. Jones was trying to get home from a long trip to see his ailing wife. Mrs. Jones had been ill for several years, suffering a great deal of pain. His flight was to leave at 7:00 PM. Upon arrival at the airport in New York at 4:30 PM, he inquired at the ticket counter, "Is there an earlier flight that I can take to Washington?" The counter agent responded, "There is plenty of room on the 5:00 PM flight, but you will have pay a $200 change fee." The passenger inquired, "Could you please waive the change fee? I need to get home to my ailing wife." The ticket agent responded, "Sorry, your ticket does not allow me to make the change. You can, however, try at the gate."

The passenger made a second attempt at the gate to get on an earlier flight, but the manager at the gate was unwilling to authorize the change, saying, "I don't make the rules."

Mr. Jones decided to give it one more try. He called the airline's customer service center. The customer service agent responded to Mr. Jones's plea: "We cannot overrule the agent at the gate. Sorry, you just got the wrong supervisor. He is going by the book."

—Anonymous

***Discussion***

1. Should rules be broken for a higher good? Discuss your answer.
2. Do the rules seem to be consistently or inconsistently applied in this **Reality Check**? Discuss your answer.

## Conscientiousness

*The most infectiously joyous men and women are those who forget themselves in thinking about and serving others.*

—Robert J. McCracken

A *conscientious* person is one who has moral integrity and a strict regard for doing what is considered the right thing to do. A person acts conscientiously if he or she is motivated to do what is right, believing it is the right thing to do. Conscience is a form of self-reflection on and judgment about whether one's actions are right or wrong, good or bad. It is an internal sanction that comes into play through critical reflection. This sanction often appears as a bad conscience in the form of painful feelings of remorse, guilt, shame, disunity, or disharmony as the individual recognizes that his or her acts were wrong.

## REALITY Kill the Messenger

Frank, working as a hospital inspector, found a number of things wrong in his recent building inspection. At first glance the building looked clean and polished—Frank was amazed by how the floors sparkled in the old building. But then, as Frank always does, he asked to look behind a corridor door. Behind the door, Frank found a small storage closet with medical records strewn on the floor and others stored in cardboard boxes. The records had been soaked by water and floor wax that had seeped under the door when the corridors where cleaned. Entries on the records were blurred, making them difficult to read, and the records appeared to have black mold growing on them.

Behind another door was a medical equipment repair room. Dust balls floated on the floor as the door was opened. There was food on the floor, and a can of soda had been spilled and allowed to dry. Equipment parts were also scattered on the floor.

The staff complained about Frank's findings. Before he left, the staff corrected the issues he had noted and asked, "Frank, could you remove these comments from your report. We cleaned the room and it is spotless. In addition, we stored the records in the medical records department." Frank replied, "I could not in good conscience remove my findings. Yes, the room may be clean, but what about the information that had been recorded on the medical records that is not readable? Further, our process for inspecting your facility is a sampling process. I did not look behind every door, and I am not sure what we would find if we did. I would suggest, as we discussed earlier, that a written plan of action be prepared and implemented to address the issues I identified. More important, your action plan should be implemented facility-wide. For example, no boxes should be stored on the floors, including medical supplies, as well as medical records."

—Anonymous

***Discussion***

1. Should Frank have overlooked his findings, as the staff pressed him not to report them? Discuss your answer.
2. Assuming you were Frank, would you have deleted the findings from your report? Explain your answer.

## Discernment

*Get to know two things about a man—how he earns his money and how he spends it—and you have the clue to his character, for you have a searchlight that shows up the innermost recesses of his soul. You know all you need to know about his standards, his motives, his driving desires, and his real religion.*

—Robert J. McCracken

*Discernment* is the ability to make a good decision without personal biases, fears, and undue influences from others. A person who has discernment has the wisdom to decide the best course of action when there are many possible actions to choose from.

### REALITY 9/11 Value Judgment

James had been scheduled to fly Monday evening, September 10, 2001, from Ronald Reagan Washington National Airport to New York LaGuardia Airport, and then rent a car and drive to Greenwich, Connecticut, where he was assigned to inspect a hospital. As luck would have it, there was one flight cancellation after another. After the last flight to LaGuardia was canceled, he went to the ticket counter and scheduled the first flight out Tuesday morning, September 11, 2001, at 6:00 AM.

The following morning James flew into LaGuardia, picked up his car, and drove to Connecticut to work with an assigned team led by Dr. Matthews. Not long after he arrived at the hospital, the first plane hit the World Trade Center. Shortly after the second plane crashed into the World Trade Center, the corporate office called and asked if the hospital wanted to reschedule the survey. The hospital opted to continue the survey.

On Thursday, the last day of the survey, a hospital staff member approached Dr. Matthews and asked if he and his survey team would like to attend a short memorial service in the lobby at noon for the victims and workers of 9/11. Without hesitation, Dr. Matthews replied, "No, we really have to finish our reports."

—Anonymous

#### *Discussion*

1. Did the team leader make an appropriate decision? Discuss your answer.
2. Describe the various virtues and values that come into play in this case.
3. Discuss how you would have addressed the hospital's request to attend the memorial service.
4. Realizing that hindsight is 20/20, could you defend the decision not to attend the ceremony? Explain your answer.

## Fairness

*Do all the good you can, By all the means you can, In all the ways you can, In all the places you can, At all the times you can, To all the people you can, As long as you ever can.*

—John Wesley

In ethics, *fairness* requires each person to be objective, unbiased, dispassionate, impartial, and consistent with the principles of ethics. Fairness is the ability to make judgments free from discrimination, dishonesty, or one's own bias. It is the ability to be objective without prejudice or bias. We often tolerate mediocrity. We sometimes forget to thank those who just do their jobs, and we often praise the extraordinary, sometimes despite questionable faults. To be fair, it is important to see the good in all and to reward that good.

Questions of fairness in the Affordable Care Act have led to lawsuits in a number of the nation's top hospitals including the Mayo Clinic in Minnesota and Cedars-Sinai in Los Angeles because they are cut out of most insurance plans sold on the exchange.

### NEWS Health Costs Cut by Limiting Choice

As Americans have begun shopping for health plans on the insurance exchanges, they are discovering that insurers are restricting their choice of doctors and hospitals in order to keep costs low, and that many of the plans exclude top-rated hospitals. . . . The result, some argue, is a two-tiered system of health care: Many of the people who buy health plans on the exchanges have fewer hospitals and doctors to choose from than those with coverage through their employers.

Insurers "looked at the people expected to go on the exchanges and thought: 'these are people coming out of the ranks of the uninsured. They don't care about the Mayo Clinic or the Cleveland Clinic. They will go to community providers,'" explained Robert Laszewski, a consultant to the health-care industry.

—Sandhya Somashekhar and Ariana Eunjung Cha, *The Washington Post*[41]

Although care is generally cheaper at community-based hospitals than academic medical centers, the quality of that care often comes into question, as noted in the preceding **Reality Check**.

## REALITY Community Hospital vs. Respected Medical Center

My closest friend Nick was admitted to a small community hospital for what was described as a minor surgical procedure. During surgery, the surgeon unknowingly nicked the large bowel, which went unidentified for several days. Nick, as a result, developed a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. Further surgeries were conducted, complicating an already botched surgery. One evening a nurse called his family aside and said, "Although I am jeopardizing my job, I would get Nick out of here if I was you." The family decided to move Nick to a major teaching medical center several hours away from his hometown. Following an extended stay at the medical center and discharged home under hospice care, I visited Nick at his home. He looked intensely straight at me with deep sadness and said, "They took my life from me." He told another friend, "My life is over."

—Anonymous

So where are we as it relates to fairness in the delivery of health care? Is it true that people coming out of the ranks of the uninsured don't care about the Mayo Clinic, Cleveland Clinic, the Lahey Hospital and Medical Center, or the Massachusetts General Hospital, to name but a few? Or perhaps they do care, but just don't know the quality differences from one hospital to the next? Or is it a question of accessibility in remote areas of the country? Do we need hospital selection exchanges more than we need insurance exchanges? If one has money or connections, is one more likely to get a higher quality of medical care than a poorer patient? Who determines what routine care is? Is routine care based on each patient's needs and comorbidities? Should those who have a financial interest in where a patient is treated be excluded from the decision-making process?

Cheaper is not always better and providing "care" may not be enough. Although fairness in the delivery of health is a laudable value, it is most likely unachievable. The disparity as to who holds the nation's wealth continues to widen, as noted in the news clippings that follow. With so much wealth in the hands of the few, fairness in the delivery of high-quality health care for all is unlikely. However, the human race must continue to strive to meet the needs of all.

## NEWS Of the 1%, By the 1%, for the 1%

Americans have been watching protests against oppressive regimes that concentrate massive wealth in the hands of an elite few. Yet in our own democracy, 1 percent of the people take nearly a quarter of the nation's income—an inequality even the wealthy will come to regret.

—Joseph E. Stiglitz, *Vanity Fair*, May 2011

## NEWS World's Richest 1% Own 40% of All Wealth, UN Report Discovers

The richest 1% of adults in the world own 40% of the planet's wealth, according to the largest study yet of wealth distribution. The report also finds that those in financial services and the internet sectors predominate among the super-rich.

Europe, the US and some Asia Pacific nations account for most of the extremely wealthy. More than a third live in the US. Japan accounts for 27% of the total, the UK for 6% and France for 5%.

—James Randerson, *The Guardian*, December 2006

## Fidelity

*Nothing is more noble, nothing more venerable, than fidelity. Faithfulness and truth are the most sacred excellences and endowments of the human mind.*

—Cicero

*Fidelity* is the virtue of faithfulness, being true to our commitments and obligations to others. A component of fidelity, veracity, implies that we will be truthful and honest in all our endeavors. It involves being faithful and loyal to obligations, duties, or observances. The opposite of fidelity is infidelity, meaning unfaithfulness. Caregivers must be faithful to their duties and obligations to provide quality patient care.

The Supreme Court of New Jersey in *Perna v. Pirozzi*[42] determined that a patient's consent form did not apply to the partners in a group practice. The patient had specifically requested Dr. Pirozzi to perform the surgery. However, a different surgeon in the group performed the surgical procedure.

Apparently, this was a common practice in the group and the surgeon who was working in the operating room on the scheduled day of surgery performed the surgery. The patient only learned that a different surgeon had performed the surgery when he was readmitted to the hospital due to post-surgical complications.

Mr. Perna first learned of the identities of the operating surgeons when he was readmitted to the hospital on June 11 because of post-surgical complications. Subsequently, Mr. and Mrs. Perna filed suit for malpractice against all three doctors, alleging four deviations from standard medical procedure concerning the diagnosis, treatment, and surgery performed by the defendants. They further alleged that there was a failure to obtain Mr. Perna's informed consent to the operation performed by Dr. Del Gaizo. That is, plaintiffs claimed that Mr. Perna's consent to the operation was conditioned upon his belief that Dr. Pirozzi would be the surgeon.[43]

The failure of a surgeon to perform a medical procedure after soliciting a patient's consent, like the failure to operate on the appropriate part of a patient's body, is a deviation from standard medical care. It is malpractice whether the right surgeon operates on the wrong part or the wrong surgeon operates on the right part of the patient. In each instance, the surgeon has breached his duty to care for the patient. Where damages are the proximate result of a deviation from standard medical care, a patient has a cause of action for malpractice.

Although an alternative cause of action could be framed as a breach of the contract between the surgeon and the patient, generally the more appropriate characterization of the cause will be for breach of the duty of care owed by the doctor to the patient. The absence of damages may render any action deficient, but the doctor who, without the consent of the patient, permits another surgeon to operate violates not only a fundamental tenet of the medical profession but also a legal obligation.[44]

The patient was given a cause of action for battery against the surgeon who actually performed the operation. Thus, the patient could recover for all injuries resulting from the mere performance of the operation, even if the operation had been properly performed. Absent emergency, patients have the right to determine not only *whether* surgery is performed but also *who* performs the surgical procedure.

Few decisions bespeak greater trust and confidence than the decision of a patient to proceed with surgery. Implicit in that decision is a willingness of the patient to put his or her life in the hands of a known and trusted medical doctor. Sometimes circumstances will arise in which, because of an emergency, the limited capacity of the patient, or some other valid reason, the doctor cannot obtain the express consent of the patient to a surrogate surgeon. Other times, doctors who practice in a medical group may explain to a patient that any one of them may perform a medical procedure. In that situation, the patient may accept any or all the members of the group as his surgeon. In still other instances, the patient may consent to an operation.[45]

## Freedom

*You can only protect your liberties in this world by protecting the other man's freedom. You can only be free if I am free.*

—Dorothy Thompson

*Freedom* is the quality of being free to make choices for oneself within the boundaries of law (**FIGURE 1-2**). Freedoms enjoyed by citizens of the United States include the freedom of speech, freedom of religion, freedom from want, and freedom from physical aggression. In health care, the freedom to consent to a medical procedure or refuse treatment is an unequivocal right of a competent patient who is capable to choose or assign a surrogate to choose for him.

Freedom of choice is not always recognized as a given. For example, "If you can afford health insurance but choose not to buy it, you may pay a fee called




**FIGURE 1-2** Freedom Speaks.

the individual shared responsibility payment. (The fee is sometimes called the 'penalty,' 'fine,' or 'individual mandate.')."[46] The "Freedom of Choice in Health Care Act" Section 2 provides:

> The people have the right to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The legislature may not require any person to participate in any health care system or plan, nor may it impose a penalty or fine, of any type, for choosing to obtain or decline health care coverage or for participation in any particular health care system or plan.[47]

And so goes the battle as it rages on, and the right to choose is not necessarily absolute.

## Honesty/Trustworthiness/ Truth Telling

*A lie can travel halfway around the world while the truth is still putting on its shoes.*

—Mark Twain (American humorist, writer, and lecturer, 1835–1910)

*Honesty* and trust involve confidence that a person will act with the right motives. It is the assured reliance on the character, ability, strength, or truth of someone or something. To tell the truth, to have integrity, and to be honest are most honorable virtues. *Veracity* is devotion to and conformity with what is truthful. It involves an obligation to be truthful.

*Truth telling* involves providing enough information so that a patient can make an informed decision about his or her health care. Intentionally misleading a patient to believe something that the caregiver knows to be untrue may give the patient false hopes. There is always apprehension when one must share bad news; the temptation is to play down the truth for fear of being the bearer of bad news. To lessen the pain and the hurt is only human, but in the end, truth must win over fear.

*Speaking the truth in times of universal deceit is a revolutionary act.*

—George Orwell

Physicians often find it difficult to disclose medical errors to their patients. Generally, they are often fearful that errors can lead to malpractice suits. Even so, it the responsibility of physicians to disclose medical errors involving their patient's care. The *Journal of the American Medical Association*, in its February 26, 2003, issue, addresses the importance of encouraging physicians to disclose medical errors and the need to support them in their struggles to comply with policies requiring the disclosure of errors to their patients.[48]

By not disclosing a medical error, the doctor conspicuously places his own interests above that of the patient to the detriment of the patient, thereby violating a patient-centered ethic. Moral courage is therefore needed if doctors are to do the right thing when medical errors occur. This moral courage can be facilitated by institutions having policies and guidelines on disclosure of errors in place, training doctors and other hospital staff on how to disclose medical errors and providing emotional support for doctors who make mistakes in their efforts to treat patients and save lives.[49]

Physicians who fail to discuss medical errors with their patients are more likely to face lawsuits than those who disclose and discuss their errors with patients. "Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by multiple ethicists and professional organizations. In addition, hospital accreditation standards and some state laws now require that patients be informed about 'unanticipated outcomes' in their care."[50]

Although physicians are reluctant at times to speak up and admit to medical errors, there are those who do as noted in the following news clipping.

### NEWS Medical Errors Are Hard for Doctors to Admit

In 2007, I published a story in my local paper in which I confessed to having made a medical error years earlier. I'd mistakenly prescribed an antibiotic for a patient whose chart indicated an allergy to the drug.

Thankfully, the story had a happy ending. My patient recovered and took no legal action after I explained to her what had happened. I ended my article vowing to take greater care to prevent errors and urging doctors to take responsibility for their mistakes, even when a patient hasn't been harmed.

—Manoj Jain, Health and Science, *The Washington Post*, May 27, 2013[51]

## REALITY 36,000 Feet Over Texas

A few weeks before Frank was to travel to Dodge City, Texas, for a work assignment involving the survey of a hospital for accreditation purposes, he received a call from Dr. Layblame.

"Hi, Frank. This is Dr. Layblame. Can you be ready for an early afternoon departure from Dodge City on Friday?"

Frank replied, "Well, you know, we have been instructed not to leave early, and I can book a flight to leave Saturday morning."

Dr. Layblame emphatically replied, "Well, I was assigned as the team leader on a multiple-hospital tour here in Texas, and the rest of the team and I are planning an early start, as we have to drive to our next assignment. You were an add-on for this particular survey, and it's my decision to make. The team wants to get to the next location, settle in to our next hotel, and have time to enjoy an evening meal together. So you should be prepared for an early exit by preparing your report Thursday evening before the exit conference on Friday. You can book to fly out late Friday afternoon."

Frank booked the last flight out of Dodge City, with a 15-minute ride from the hospital to the airport. The flight left at 4:30 PM. On hearing Frank's schedule, Dr. Layblame observed, "Well, it's only an hour early. If you write most of your report the night before and during lunch on Friday, we should be able to finish up work by 2:30 PM. The airport is small and close to the hospital. I am the tour leader, so it should not be a problem."

While Frank was on a flight to Washington, DC, following his work assignment, Ronald, Frank's supervisor, was dictating a voicemail message to him. When Frank returned home at about 10:30 that evening, he retrieved his voicemail messages. Ronald had left Frank a message at 4:30 PM earlier that day asking Frank, "Call me as soon as you get this message. I will be in my office until about 5:30 PM. If you miss me, you can reach me over the weekend. My cell phone number is 888-888-8888."

Frank called Ronald that evening and the next morning; however, Ronald never answered, nor did he return his call. Frank called Ronald Monday morning. As luck would have it, Ronald was out of the office for the day. Frank called Ronald again on Tuesday morning and Ronald answered. Frank asked, "Ronald, you called?" He replied, "Yes, I did. How were you able to get to the airport on Friday and catch a 4:30 PM flight without leaving your job early? I had your flight schedule and you left the survey early. You could not possibly have traveled to the airport in time to catch your flight without leaving early."

Frank replied, "I did not schedule the exit time from the survey. The physician team leader determined the time of the exit. He said that he was conducting a system tour and would like to get the exit briefing started as soon as possible. He asked for everybody to be ready to exit by having draft reports ready the night before." Ronald replied, "Dr. Layblame told me the team had to exit early because you scheduled an early flight."

Frank asked, "Just one question, Ronald. Why would you leave a message for me at 4:30 PM to call you by 5:30 PM when you knew I was 36,000 feet high in the sky? And why didn't you call the team leader at the beginning of the assignment and not after it was completed? Since you know flight schedules, why would you wait until the assignment was completed to raise this issue? Sounds a bit peculiar, don't you think? Sort of like observing a protocol not being followed in the OR and then chastising the OR team after the surgery is completed for not following protocol. This is a serious business we are in. You need to ask yourself why you would allow an event to occur if you believed it to be wrong."

—Anonymous

### *Discussion*

1. Discuss the ethical issues involved in this case.
2. Discuss what you would do if you found yourself in Frank's situation.
3. What should Frank have said if his manager said, "You should have reported Dr. Layblame"?
4. How would you describe Ronald's management style?

## *Declining Trust in the Healthcare System*

The declining trust in the nation's ability to deliver high-quality health care is evidenced by a system caught up in the quagmire of managed care companies, which have in some instances inappropriately devised ways to deny healthcare benefits to their constituency. In addition, the continuing reporting of numerous medical errors serves only to escalate distrust in the nation's political leadership and the providers of health care.

Physicians find themselves vulnerable to lawsuits, often because of misdiagnosis. As a result, patients are passed from specialist to specialist in an effort to leave no stone unturned. Fearful to step outside the boundaries of their own specialties, physicians escalate the problem by ineffectively communicating with the primary care physician responsible for managing the patient's overall healthcare needs. This can also be problematic if no one physician has taken overall responsibility to coordinate and manage a patient's care.

## NEWS Cancer Doctor Allegedly Prescribed $35 Million Worth of Totally Unnecessary Chemotherapy

A Michigan oncologist has been charged with giving $35 million in needless chemotherapy to patients—some of whom didn't even have cancer, *The Today Show* reported.

Popular physician Farid Fata, who had more than 1,000 patients, allegedly misdiagnosed people with cancer just so he could bill Medicare.

He's also accused of giving chemo to "end-of-life" patients who wouldn't benefit and had to endure the treatment's nasty side effects during their final days.

—Christina Sterbenz, *Business Insider*, August 15, 2013

### Politics and Distrust

*Lies or the appearance of lies are not what the writers of our Constitution intended for our country—it's not the America we salute every Fourth of July, it's not the America we learned about in school, and it is not the America represented in the flag that rises above our land.*

—Anonymous

Truthfulness is just one measure of one's moral character. Unfortunately, politicians do not always set good examples for the people they serve. The following news clipping is an example of how political decisions can lead to distrust in government.

## NEWS Cheney's Staff Cut Testimony on Warming

In a letter to Sen. Barbara Boxer (D-Calif.), former EPA deputy associate administrator Jason K. Burnett said an official from [Vice President Dick] Cheney's office ordered last October that six pages be edited out of the testimony of Julie L. Gerberding, director of the Centers for Disease Control and Prevention. Gerberding had planned to say that the "CDC considers climate change a serious public health concern."

—Juliet Eilperin, *The Washington Post*, July 9, 2008

#### Discussion

1. Discuss how headlines such as this affect your opinion of politicians.
2. Assuming a cover-up, discuss how the principles of beneficence and nonmaleficence apply.
3. At the end of our days, the most basic principles of life—trust and survival—are on trial. What is your verdict, if indeed there was a cover-up?

## Integrity

*Nearly all men can stand adversity, but if you want to test a man's character, give him power.*

—Abraham Lincoln

## NEWS Wrong-Operation Doctor

*Hospitals find it hard to protect patients from wrong-site surgery*

Last year a jury returned a $20 million negligence verdict against Arkansas Children's Hospital for surgery on the wrong side of the brain of a 15-year-old boy who was left psychotic and severely brain damaged. Testimony showed that the error was not disclosed to his parents for more than a year. The hospital issued a statement saying it deeply regretted the error and had "redoubled our efforts to prevent" a recurrence.

"Healthcare has far too little accountability for results. . . . All the pressures are on the side of production; that's how you get paid," said Peter Pronovost, a prominent safety expert and medical director of the Johns Hopkins Center for Innovation in Quality Patient Care, who added that increased pressure to turn over operating rooms quickly has trumped patient safety, increasing the chance of error.

—Sandra G. Boodman, Kaiser Health News, *The Washington Post*, June 20, 2011

#### Discussion

1. Discuss the issues of integrity in this case.
2. Should criminal charges be a consideration in this case, if accurately reported? Discuss your answer.

*Integrity* involves a steadfast adherence to a strict moral or ethical code and a commitment not to compromise this code.

> There are many ways integrity is defined. Most of us have heard integrity defined as what you do when nobody else is around, or what you do and how you do it on a daily basis. Integrity is a concept that includes consistency in actions, expectations, measures, methods, outcomes, principles, and

> values. Integrity means our actions are honest and trustworthy.[52]

A person with integrity has a staunch belief in and faithfulness to, for example, his or her religious beliefs. Patients and professionals alike often make healthcare decisions based on their integrity and their strict moral beliefs. For example, Jehovah's Witnesses generally refuse blood transfusions because it is contrary to their religious beliefs, even if such refusal may result in death. A provider of health care may refuse to participate in an abortion because it is against the provider's moral beliefs. A person without personal integrity lacks sincerity and moral conviction and may fail to act on professed moral beliefs.

> Having integrity means doing the right thing in a reliable way. It's a personality trait that we admire, since it means a person has a moral compass that doesn't waver. It literally means having "wholeness" of character, just as an integer is a "whole number" with no fractions.[53]

Integrity begins at the top of an organization with the governing body to select a leader who exhibits the virtue of integrity. The success of the right choice is described in a quote by Bessie Anderson Stanley (see the opening quote in the Front Matter).

The career of a successful CEO is described in the following **Reality Check**.

## REALITY Man of Integrity

How we want to be remembered by all throughout our career:

*June 1978: Congratulations and good wishes on your appointment as administrator. This is a great responsibility, but you are young and capable and it should be an interesting challenge. Most people of all stations working in the hospital are behind you and you certainly have the backing of the medical staff. This is a very good start. We will work 100% with you so please feel that you have our sincere backing. Once again, congratulations, good luck and good management.*

—Bob

*July 1978: Following our conversation yesterday, and for whatever it's worth, I'd just like to tell you that I think you're doing a terrific job! I like your administrative style and feel comfortable already. I'm very happy to be working with you. Have a good day!*

—Yvonne

*September 1998: Good luck in all your endeavors. It was my good fortune to be associated with you. People who are people-oriented should do well in any career path they choose. Happiness and good health.*

—Natalie

*November 2008: Daniel, before we talk about anything else, I want to first of all thank you for your approach to our staff. I want you to know I was happy to have had the pleasure to work with you. You had a wonderful way to put people at ease and glean information from them. You were able to determine from your questions the quality of care we offer here at Hennepin. When I think of the book, 'If Disney ran your hospital' and the fact that you went over and beyond what the book teaches … I saw that in you. I have a report somewhere here on my desk as to staff feedback and how well you related to them … You should see it. I am off to a meeting right now but I will share it with you.*

—Jeanette

The integrity of the numbers of an employee satisfaction survey that were presented to employees during an annual educational conference is highlighted in the **Reality Check** presented here.

## REALITY Employee Satisfaction Survey

The human resources department manager was reporting on an employee satisfaction survey at a leadership roundtable session with the organization's employees. To maintain employee confidentiality, a third-party consulting firm had conducted the survey. Approximately 49% of employees had responded to the survey, compared with 47% 3 years earlier. The HR manager commented that it is was the first satisfaction survey conducted in 3 years and that the results were excellent, with a 4.2% rise in overall employee satisfaction. Management was all smiles as they sat listening to the report. The HR manager had actually briefed the organization's leadership prior to the roundtable session. Following the