The author draws upon his comments to CRNAs and nurse anesthesia students (made at the Student Luncheon at the 49th AANA Annual Meeting in Boston during August, 1982) in this two-part feature on bioethics. In Part I, he defines medical ethics and the growing popular interest in this branch of philosophy.

Situation: A surgeon who has a reputation as a "hustler" wants to place a feeding gastrostomy tube in a 94-year-old terminal cancer patient who, following preoperative physical evaluation, is determined to be a physical status 5.

Question: What ought the anesthetist do? What does duty and obligation require? Should the anesthetist cooperate or refuse to participate in the procedure?

This case, with its follow-up questions, is one of five which was presented to me by nurse anesthesia students who had expressed a need for some help in managing ethical issues in their professional work. If I had been consulted by more experienced anesthetists, the list of cases would have been longer, more complicated, and I suspect, some at least, shocking enough to be of interest to the producers of "60 Minutes" or "Days of Our Lives." It is important to note that even student anesthetists have become aware of the fact that moral decisions cannot be radically separated from professional judgments or considered peripheral to professional conduct.

Like other health care professionals, anesthetists face problems today that cannot be solved by learning more science or developing better clinical techniques. Both beginning and experienced clinicians understand that professional competence now means being competent in ethical decision-making as well as in the traditional skills. After being educated to perform complex procedures, anesthetists have to ask further questions: "Should I do this? Is this the right thing to do? Do I have a duty to cooperate in this procedure? Ought I withdraw from this case?" Should, ought, right, duty—these are ethical terms and introduce ethics into the day-to-day work of the anesthetist.

What is ethics?

Ethics is a part of philosophy and is ordinarily understood as a "science" of right and wrong. Doing ethics means to engage in a systematic reflection on what should or should not be done. Making rationally defensible judgments about behavior is another way of viewing ethics. Justifications are developed by reference to standards of evaluation called principles and rules. These same standards serve as action guides and are derived from a vision of life. Ethics covers many aspects of human experience and at some point, always touches on basic philosophical or religious meanings.
It would be a mistake, however, to think of ethics as solely a matter of philosophical reflection, action guides, and religious belief. Ethics is rooted in life and relationships. Unavoidably, questions about right and wrong are generated by a human capability of doing one thing rather than another, of reacting in this way or that, of incorporating justice or injustice into one's response to people and events.

As human beings, we are concerned with should and ought because our response to other persons or situations is not fixed or determined. We can make assessments of the situations to which we must respond; we can foresee the consequences of our decisions; with some imagination we can develop alternative ways of acting. Since we can act one way or another, our responses are not automatically adjusted but rather, must be made just. We human beings are ethical animals. In fact, we are condemned to be ethical.

The cases given to me by the students reflect every aspect of what is meant by ethics. A preliminary assessment of the situation had to be made and it turned up a question about right and wrong. Certain unsavory consequences have already been envisioned, and it is implied that there are alternatives which need careful consideration. The student inquiries show a sense of the need to be responsible. The human capacity to step back from a situation involving other persons and to recognize that the just or right response needs to be fashioned by the actor—all of this is implied by the students' formulation of the cases and their requests for guidance. Thus, nurse anesthesia students are already doing ethics.

Concerns like those presented by the students are now addressed in a new specialty of philosophical ethics called bioethics. Many different professionals are involved in this new field: lawyers, theologians, nurses, physicians, and philosophers. However, just as ethics generally is not primarily the work of experts, but of ordinary people struggling to find the just response to their concrete life situations, so bioethics is primarily the work of health care professionals trying to find the right-making and wrong-making features of their actions, roles, and attitudes. Outside specialists may help, but the ethics which is done in hospital and clinical settings is done by health care persons.

This article is a reflection on cases presented to me by students; it does not presume to tell anesthetists what to do. Rather than setting out specific answers, this article has a much more modest goal. My hope is to help nurse anesthetists sort out their conflicts so they can make their own ethical decisions with more confidence and strength.

**Medical ethics**

Medical ethics has been around for at least 2,500 years and probably much longer. There were books written specifically about medical ethics which date back many centuries. More than 25 years ago, I took a course in medical ethics which was a standard part of a program in theology. But in the past, medical ethics did not cause much excitement. It was a concern mainly of theologians and some physicians. Certainly it was not a matter of wide public interest.

Twenty-five years ago, one never saw articles about medical ethics in newspapers or weekly news magazines, and certainly there were no television specials on medical ethical topics. There were no journals of medical ethics, no academic programs training specialists in this area, and no research institutes focusing exclusively on medical ethical dilemmas. Things have changed, however, especially in the last decade.

In the remote past this particular type of ethics took the form of codes or rules which spelled out what was expected of the good doctor. The Hippocratic oath was followed by other codes which were devised by physicians and supported by professional organizations like the AMA. The old medical ethics courses amounted to a look at the codes and the application of certain ethical principles to a few special problems of medicine. The courses in my theology program were concerned primarily with issues of life and death. The principles “respect for life” and “do not kill” were examined and refined by relating them to questions about fetal life and comatose patients. We asked whether the full impact of the respect for life principle applied to the embryo and to the person in a coma. We wondered whether withholding of treatment was the same as killing, and whether the administration of pain relief which may cause death could be justified.

The Hippocratic oath and other medical codes have not disappeared, and neither have the life-and-death issues. Today, however, the field has been considerably expanded. Bioethics now covers practices and policies in all areas of health care. It is concerned with the many ethical implications of both clinical practice and research. Public policy on medical issues in the forms of regulation, legislation, and judicial decisions have proliferated and abound with references to ethics.

In effect, what was only a short time ago (and
for centuries before), a narrowly defined area generating very limited interest, has become greatly expanded. Now medical ethics is the preoccupation of prime-time television specials and the material for cover stories of widely circulated news magazines. The fact that an article on medical ethics is appearing in your professional journal is itself a sign of the times.

New ethical questions

The reasons for these changes are not difficult to understand. Medical science has made impressive advances in the last quarter-century, and with every new medical capability comes a string of new ethical questions. When little or nothing could be done for the sick and dying, ethics was relatively simple: it was more a matter of rules and principles of nursing than anything else. But with new technologies has come new power, and in its wake a host of questions about whether it is good, right, and just to do what can now be done. Questions also abound about who should make decisions. The increased interest in medical ethics is a reflection of increased interest in medicine generally, but even more a tribute to the new power of modern health sciences.

The following is an example showing how new technologies create new options and sometimes tough ethical questions. A procedure used to make a diagnostic assessment of the fetus through retrieval and examination of amniotic fluid created ethical questions about the use of this procedure for non-medical reasons such as curiosity about the sex of the fetus. But this diagnostic instrument also generated questions about whether to abort a defective or potentially defective new life. Now, however, even more sophisticated procedures have been developed, making possible surgical intervention in order to treat some previously life-threatening conditions in the fetus.

Correspondingly, new questions have arisen about who can give consent or refuse consent for these interventions. In addition, this advance in technology has actually changed the ethical status of the fetus for many physicians and nurses who all of a sudden have begun to talk about their "little patients" and to adopt more aggressive positions of advocacy for them.

Technological advances can now prolong life for a very long time. The respirator alone has created many new ethical questions and is responsible for a mountain of literature on ethical treatment of the sick and dying. But mechanical advances are not the only source of new ethical dilemmas. Informed consent issues resulted from the application of underlying assumptions about individual self-determination to medicine and the doctor-patient relationship. Insurance plans and third-party payers have also created touchy issues about revealing medical data.

Can an age-old ethical rule of confidentiality continue to be respected when someone other than the patient pays the medical bills? Under what conditions should research be done on human beings? Who should be treated with high-priced therapies when all cannot benefit from them? Are behavior-controlling medications a violation of individual rights? These are just a few of the new questions addressed by bioethics. That medical ethics has ceased to be a narrow specialty and become a widespread concern is neither a fluke nor a mystery.

Limitations of medical ethics

New specialties which attract public attention can easily be oversold. Look at what happened to psychiatry in this century. Before commenting on cases which are characteristic of the ethical problems of nurse anesthetists, I want to first make a few disclaimers about what can be expected of medical ethics and medical ethicists.

Medical ethics tries to establish standards for right and wrong, but it is not a reform movement in medicine. Exposés of human experimentation, the overuse of medical tests, and fraudulent surgery are not the responsibility of a medical ethicist. Without judging whether exposes are good or bad, there is a difference between the ethicist and the reformer. It is hoped that the reformer will be ethical; but the ethicist is not a reformer.

I will go farther and say the ethicist should leave reformation to health care professionals. Reformation in the best of circumstances is difficult to accomplish. It simply cannot be done by outsiders. Let the health professionals and hospital administrators reform. They can be aided by reform-minded lawyers and sociologists. The ethicist has other business to attend to.

Neither is the ethicist a font of inspiration, motivating people working in hospitals or involved in medical training to attain higher levels of ethical functioning. My comments are not likely to inspire anyone to virtue. The same would be true if I were on the staff of a medical faculty and responsible for teaching doctors or nurses. Teaching can be inspirational, but inspiration is different from instruction. It is also different from homiletics (the art of effective preaching). Ethics can be used both to diagnose certain medical situations and to offer suggestions for therapy, but it cannot be counted
on to be inspiring. I cannot speak for all moral philosophers, but very few of the many ethicists I know would qualify as inspirational.

Finally, ethicists cannot give specific and definitive answers about what is right or wrong in a particular case. Ethics provides general guidelines for action and rules for distinguishing good from bad, but these cannot be applied so as to come up with exactly the right thing to do in complex medical situations. Justice, love, truth, autonomy, beneficence, fidelity—all provide broad and general guidelines for action, but these principles do not generate only one specific solution. Between the broad directives provided by principles such as justice or truth and a determination of what justice or truth require in a particular situation, there is a tremendous gap. Prudence and the practical moral wisdom of the health care professional fill this gap.

Those who do medical ethics as a matter of almost daily routine are nurses and physicians. They are the primary or "first-line" medical ethicists. They are usually the most appropriate moral decision-makers because they have the most experience about the issues being decided. There is a danger, however, that the nurse or doctor will put his or her own personal standards in place of the patient’s will. And there is always a danger that the common good becomes confused with the special interests of a particular medical researcher. But once these dangers are taken into account, doctors and nurses are probably the best ethicists.

Experience, especially when it is informed by a genuine commitment to the patient, counts for a great deal. The role of the professional medical ethicist is to provide help where needed, but not to take over ethical decision-making. The ethicist is one professional working with other professionals in an area of mutual concern. There is no rightful place in medical ethics for downward communication or dogmatic solutions by one specialist.

The role of a medical ethicist

Nurses and doctors do not always need help in finding the best solution to a moral problem. In some cases, the right thing to do stands out for anyone with the most primitive human sensitivity to the value dimensions of reality. In cases of needless suffering, exploitation of the patient or deceit, no special ethical training is required in order to identify right and wrong. Normal character development results in the acquisition of basic moral sensitivities, standard rules of behavior and fundamental principles exemplified by truth, freedom and justice. Healthy human beings immediately recognize that it is good to help someone who is suffering, and wrong to take advantage of someone who is seriously ill.

Medical ethics and the professional ethicists, however, do make a contribution in sorting out the many variables in a complex case, reorganizing elements in some coherent way, identifying basic conflicts, being sensitive to the implications of one or another line of action, bringing codes and principles to bear on a decision, and finally, in defending a course of action with a convincing argument. In some cases the end result of ethical reflection on a medical case will be to identify the right course of action, but sometimes, the least immoral course of action is the best that can come out of this difficult exercise.

The task of the medical ethicist begins with a sorting-out process: an attempt to remove some of the befuddlement which may surround a case. Most frequently, the situation to be responded to presents itself initially as full of ambiguity and confusion. The relevant facts need to be lifted out for special attention. The value components have to be identified. The major conflict or dilemma must be pointed out. Concepts, categories and distinctions are then employed to help find a way out of the problem. And arguments are developed to support one or another course of action.

One of the major contributions of an ethicist working with medical professionals is that of clarification. Discovery is a stronger, but perhaps too pretentious a word to describe the same process. Lived experience, whether on the street or in the hospital, is oftentimes difficult to make sense of. Academic disciplines aspire to bring clarification by breaking down and then putting back together a confusing reality. They draw lines, reorganize, distinguish, restructure, and delineate. If successful, persons in the concrete life situation are able to see more clearly and then, it is hoped, to act more justly. An unsuccessful academic discipline just adds to the confusion.

Structuring a case

Medical ethics is rooted in clinical situations and therefore centers around the task of making a morally appropriate response in that context. Some would claim that clinical experience alone is all that is required for doing ethics. No particular training in ethics is called for, they say, because ethical direction somehow emerges from continued contact with cases. At the opposite extreme are those who insist on a clear understanding of philosophical or theological theories of right and wrong in order to make good decisions. For these in-
individuals, no familiarity with the clinical setting is required—only a clear mastery of concepts and paradigms.

Obviously, both extreme positions are flawed. Medical ethics has its theoretical and conceptual components, but it is also very much an applied discipline. Without hands-on experience with cases in all their complexities and an ability to analyze these cases, medical ethics is just another exercise in abstraction. An ethical analysis of concrete cases, however, is not a mysterious activity. In can be taught and learned. What follows is a five-part framework for separating the different elements of a case and proceeding to a reasoned conclusion about the right or wrong thing to do.

I. The medical issues: Reorganizing a case so as to clarify the real issue and to work toward a just response, begins with the identification of the medical issues: diagnosis, treatment alternatives, risks, benefits, and the like. For example, the consequences of not giving a transfusion in one situation may be minimal, in another it may mean certain death. In the case with which we opened this discussion, the medical facts alone—the type of cancer, its progress, the dismal prognosis—provide a strong indication of what should and should not be done to the patient. Once the facts are known and agreed to, then right and wrong can be perceived both intellectually and effectively.

In some cases, a great deal more reflection is required, but there are times when fairly universal standards of right and wrong are immediately applicable once the facts are clear. Medical facts, then, including consequences of different treatments and alternate possibilities are obviously connected to any determination of the right or wrong thing to do. Right and wrong in medicine starts with a thorough understanding of the medical situation.

II. The human factors: All non-medical aspects of the case can be lumped together under human factors. This category covers the lived situation of the patient in question, his or her role responsibilities, economic situation, and family status. The fact that the patient in our case is 94-years-old has a lot to do with deciding what is right. Psychological issues, too, are especially important and in some cases need to be identified by a competent professional.

The mental state of either the patient or the patient's family is crucial in determining their wishes or intentions, and whether or not what they are saying in a literal sense is actually what they mean. For example, the statement, "How much longer can he go on like this?" may be as close as a family member can come to asking that further treatment be stopped. Patients may also give many implicit rather than explicit indications of their own wishes and preferences. What were the real wishes of the 94-year-old woman about surgery? Knowing her wishes is very important in coming to a just decision in this case.

III. The values: Value is a very general term. It means something of worth. There are many types of values: economic, scientific, instrumental, religious. The values which must be identified in a medical case are ethical ones, and they cover a broad spectrum of reality which Plato and other early philosophers referred to under the headings of good, right, obligation, virtue, and moral judgment.

The value components of a case, then, refer to the following: feelings and intuitions about what is right and good; obligations and duties either subjectively felt or articulated in laws, codes, rules, and commandments; abstract principles like freedom, truth, justice, beneficence, fidelity, and their interiorization in virtues, goals, and ideals. Finally, value refers to value theory in the sense of philosophical arguments about the foundation of the right and the good. Common verbs like should, ought, prefer, desire, must, and adjectives like good, bad, right, wrong, responsible, usually signal the value dimension of reality.

It makes no sense to speak about values apart from the factual aspects of a case. Values are part of reality. They are attached to acts, embedded in meaningful circumstance, and associated with motives. One and the same act of physical violence in one circumstance may be praiseworthy and good—a selfless act in defense of an innocent victim. In another circumstance, the same act may be contemptible and wrong—a senseless act of aggression against an innocent victim.

Identifying the value components of a case, therefore, is not as simple as pointing to certain words. To complicate things further, the values of a patient may be different from those of the nurse or doctor; and both may be at variance with the values of a hospital administration. In our case, for example, the values of the surgeon may be the advance of surgical techniques, money and fame. The patient would not be likely to share these. She may have a very different set of concerns, interests, needs and wishes—a very different set of values.

Certain values, nevertheless, can be identified as central to the health profession; for example, caring for persons who are ill, doing whatever is
in the patient's best interest (beneficence), not exploiting or harming the patient (non-maleficence), respecting patients by awaiting consent for treatment or experimentation (autonomy), fidelity in the sense of not violating a confidence (confidentiality). But even when the value component is identified, the right thing to do is not always as easy as deciding on a course of action to bring about this value.

IV. The ethical conflict: The tough cases in medical ethics involve either a clash of values or an ethical dilemma. In the latter instance, the choice of one value means the violation of another. Where there is such a clash, justification is called for in choosing one value or course of action over another. The clash may be between one principle and another (beneficence versus autonomy), or a rule and a principle (confidentiality and truth), or a strong feeling and a rule (a conviction that this patient does not know what is best for him and the presumption of competence unless proven otherwise.)

In difficult cases, there are rules, principles, and strong feelings—all of which must be balanced and weighed in pursuit of the good. Finding the good in the sense of the best ethical response requires familiarity with medical codes, court cases, laws, and ethical treatises on the practice of medicine. The ethicist must not only identify the major values, but search for the best way of realizing some when all cannot be realized.

Bioethics in practice organizes conflict-laden material around certain broad conceptual categories such as experimentation with human subjects, the right to treatment, informed consent, truth-telling, euthanasia. Then certain distinctions, rules, and principles pertaining to these areas are spelled out and clarified. Sometimes a particular case may clearly fall under one of these broad categories, and appropriate standards for deciding right and wrong will be almost universally agreed upon. But in most cases things are not so simple. (In death and dying situations, for example, seem to be concentrated all the value conflict which characterizes contemporary medical practice.)

Identifying the basic issue is a critical step in the structurization of a medical case. If it is competently handled, then the stage is set for making a decision that is more than just the expression of a private feeling or an act taken out of frustration with complexity.

The ethical choice in a medical setting involves balancing different value components, and choosing the primary value in a conflict situation. Some values in the form of norms, principles, and standards are so intrinsically connected with good medical practice that their violation brings a long and noble tradition into jeopardy. When a case centers around one of these core values, there is near-universal agreement among health care professionals about the right course of action. But there are also situations which generate real differences of opinion because the issues are not so clear-cut or because no widely recognized core principles are involved.

V. The decision and its defense: At one time, there was near-unanimity within our society about ethical matters because most people shared the same worldview and the same standards of right and wrong. Agreement then was easier to achieve even in complex cases. Today, however, we live in a culture characterized by moral pluralism rather than unanimity. As would be expected, this pluralism shows itself among health care professionals.

Does this result in hopeless divisions about ethics within the medical community? If there are no standards that can be agreed upon, then medical ethics is dissolved into a clash of not-to-be-disputed tastes and personal preferences. To keep this from happening and to keep a long and distinguished tradition of ethics alive in medicine, a great deal of energy today is focused upon forging even wider areas of agreement about what should and should not be done.

On some issues, at least, general and widespread agreement has been accomplished. Certain options have been ruled out as unethical by a whole medical community. What may have been common practice 20 years ago in experimentation, for example, is now universally rejected as unethical. Widely held standards in other areas like death and dying, informed consent, right to treatment and right to refuse treatment, transplantation, definition of death and the like have been hammered out. Making decisions about ethics in a medical setting is not just a matter of what someone feels is right.

But there are aspects in all of the above-mentioned areas about which there is still widespread disagreement. Medical ethics, unlike a computer program, does not generate perfect consistency. Certain choices about the right thing to do are still dictated by philosophical theories or strongly held beliefs about which there is deep disagreement. In many cases, very different choices may be morally acceptable. Sometimes neither medical ethics nor the professional ethicist can say what is the only right thing to do. Good and
competent people can and do disagree, and disagreement can arise at any one of the levels of case analysis. If the structurization of the case is well done, however, people at least will understand what they disagree about; and this itself may provide for a kind of mediation.

One classic disagreement is between persons who favor the principle of beneficence, (the value of health), and persons who favor the principle of self-determination (the value of freedom and a preference for letting even sick people refuse treatments which will certainly help them). Many of the divisions today in medical ethics can be traced to differences in religious belief systems about both the nature of persons and the proper goal of medicine.

The classic disagreements between physicians and nurses are of this sort. With increasing assertiveness, nurses are standing up for the values of the patient, especially for patient autonomy. As patient advocates, they frequently find themselves in disagreement with physicians who give highest priority to other values.

Although there is much agreement about right and wrong in death and dying situations, there is still a major disagreement about whether a medical professional should ever actively administer death (active euthanasia), and disagreement as well about whether there is such a thing as a patient’s right to suicide.

Some medical professionals think that dying children should be put out of their misery. Others think the question of misery in children is debatable and that the long-term consequences of any such direct action would be seriously detrimental to medicine.

Thus, to come to a good decision on a medical case does not in itself mean the elimination of conflict or disagreement. But it does mean making a choice based on defensible reasons which are open to more than private justification. A good decision is one backed up by sound argument and founded on core values of the medical tradition. A good decision is autonomous in the sense of coming from someone who does more than obey orders blindly, and in addition, is emprincipled in the sense of being grounded on standards of right and wrong respected both inside and outside the medical profession.

The crucial question for nurse anesthetists emerges precisely at this point. Can a nurse anesthetist come to a good ethical decision in the above-mentioned sense, or is there something about the anesthetist’s role which makes autonomous and emprincipled decision-making impossible?

In the second of this two-part article on ethics (coming in the April, 1983 AANA Journal), the specific role played by the nurse anesthetist in ethics will be explored, and guidelines for making decisions will be developed.

ADDITIONAL READINGS

AUTHOR
James F. Drane, PhD, holds graduate degrees in Philosophy, Theology, Romance Languages and is an alumnus of the Menninger School of Psychiatry where he studied as an interdisciplinary fellow. He specializes in medical ethics with a particular focus on ethical issues in psychiatry. In 1981, he was a research scholar as the Kennedy Institute for Bioethics, Georgetown University, and currently he is doing research on competency to give or refuse consent to medical treatment at the University of Tennessee Center for the Health Sciences in Memphis.

Dr. Drane currently teaches philosophy at Edinboro State College in Edinboro, Pennsylvania and at the Warren State Hospital Psychiatric Residency training program. This article is based on his presentation at the Student Luncheon at the 49th AANA Annual Meeting and Professional Sessions in Boston, Massachusetts, August 31, 1982.