

# ETHICS IN HEALTH CARE AND MEDICAL TECHNOLOGIES

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**ABSTRACT.** In this paper a case is used to demonstrate how ethical analysis enables health care professionals, patients and family members to make treatment decisions which ensure that medical technologies are used in the overall best interests of the patient. The claim is made and defended that ethical analysis can secure four beneficial outcomes when medical technologies are employed: (1) not allowing any medical technologies to be employed until the appropriate decision makers are identified and consulted; (2) insisting that medical technologies be employed not merely to promote the medical interests of the patient but rather on the basis of their ability to contribute to the overall well-being of the patient; (3) challenging caregivers to reflect on the dynamic interplay between their conscious and unconscious values and consequent determinations of what is in the patient's best interests; and (4) providing a justification for selected interventions which makes possible rational dialogue between caregivers espousing different viewpoints about treatment options.

*Key words:* decision-making, medical ethics, patient care management, patient participation

## 1. INTRODUCTION

The following case was presented at ethical rounds by the head nurse of a large medical intensive care unit in a teaching hospital.

The patient is a 57 year old obese female who was transferred to the hospital following repair of an umbilical hernia. A post-surgical pathology report revealed that she had metastatic adenocarcinoma. Her chief complaint on admission was respiratory distress secondary to fluid accumulation in the abdomen. A paracentesis on the day of admission relieved the distress. Her past medical history included diabetes and hypertension. Admission diagnostic studies included a chest X-ray revealing a right pulmonary lesion and computerized tomography scan of her abdomen revealing a left ovarian mass with ascites.

Ten days after admission the patient had a subtotal hysterectomy. The surgeons were unable to remove the entire tumor mass. Four days post-operatively the patient experienced bleeding consistent with disseminated intravascular coagulation (DIC) along with sepsis. On arrival to the Intensive Care Unit

she was placed on a face mask dispensing 100% oxygen; two days later she was intubated and placed on a ventilator. In the succeeding eight weeks the patient experienced gastro-intestinal (GI) bleeding, hypotension requiring the use of pressors, ascites, gangrene of the toes, fever, wound dehiscence, and constant pain.

### *1.1. Ethical Considerations of the Case*

The nurse presenting the case noted as the chief ethical concern identifying the locus of decision-making, in particular as this influenced the nurses' desire to "keep the patient comfortable" and the medical team's desire to cease aggressive treatment. She said, "The patient was in excruciating pain throughout the hospitalization. She was placed on a morphine drip, and the only time pain was absent was when she was fully sedated. At one point, the family complained that we were 'snowing' their mother and they demanded that the drip be turned down so she could be awake for their visits". The nurse reported that the medical team and the head nurse met with the family on three different occasions to inform them of their mother's suffering. The team told the family that it would be in their mother's best interests if aggressive treatment was stopped because the patient's prognosis was poor. The family insisted that everything be done medically for the patient. They also requested that the patient not be present at any meetings of the staff and family because the family believed that the patient would lose the will to live if she knew her prognosis.

The family feared that treatment would be pulled back and paid the hospital bill in cash each week. They often yelled at the physicians complaining that they were not being told everything. Finally, the medical staff yielded to family pressure and initiated an aggressive course of chemotherapy although they had no hope that it would prove efficacious for the patient.

The ethical questions the nurse brought to the ethics review panel included:

1. Do we sedate the patient despite the demands of the family to keep her awake? The family is not here at night. Do we have the right to increase sedation for her comfort when the family is not present?
2. Is the stress of their mother's illness preventing the family from seeing her suffering? Do we secure a court appointee to make a decision in withdrawing treatment?
3. Do we insist on having the patient included in meetings?

It is the aim of this paper to demonstrate how careful ethical analysis can enable health care professionals to work with patients and family members in making treatment decisions which ensure that medical technologies are used in the overall best interests of the patient.

Recently, members of the Hastings Center Project on the Termination of

Treatment and Care of the Dying identified four central ethical values coming from the moral traditions of medicine and nursing and from the ethical, religious, and legal traditions of our society:

1. *Patient well-being – benefiting more than burdening the patient.* (Key consideration: Individual patients evaluate the benefits and burdens of a treatment and the life it offers differently. Consequently, the obligation to promote the patient's good involves identifying the benefits and burdens of the treatment from the patient's perspective).

2. *Patient self-determination.* (Places the patient at the center of the decision-making process).

3. *The ethical integrity of health care professionals.*

4. *Justice or equity* [1].

Central to the discussion of the case presented by the nurse is an analysis of patient well-being and self-determination and the ethical integrity of the health care professionals involved. Justice/equity issues will not be specifically explored in this paper.

## 2. CASE ANALYSIS

The facts of this case point clearly to a terminally ill patient with metastatic adenocarcinoma for whom the staff believe further curative medical intervention to be inefficacious. Complicating the management of the case are:

1. the staff's failure to ascertain the patient's treatment preferences early in the course of her hospitalization while she was still consistently alert;

2. the family's strong desire to control decision-making for the patient. There is strong suspicion that this is a family whose emotional functioning is impaired; and

3. the overriding concern of the nurses to promote patient comfort and alleviate suffering at any cost – possibly to the detriment of other patient values.

This case analysis will proceed with a detailed discussion of (1) identifying the locus of decision-making, and (2) patient well-being vs. patient self-determination. The obligations of health care professionals to the patient (and family) will be clearly stated. Justifications for competing courses of action will be explored.

### 2.1. *Locus of Decision-making*

#### 2.1.1. *Identifying the Appropriate Decision Maker(s)*

In this case, the patient, members of the health care team, the patient's adult children, or a court-appointed surrogate are all possible decision makers. Of great surprise to the ethics panel reviewing the patient's course of treatment was

the lack of knowledge of the patient's treatment preferences shown by the health care professionals. The family's preferences were clearly known, especially as expressed by a particularly vocal daughter. The family's preferences were clearly in opposition to the treatment plan deemed appropriate by the medical and nursing teams. However, the nurse presenting the case had difficulty articulating the patient's expressed preferences. It was obvious that the nurse knew the patient well and appeared motivated by a genuine concern for her welfare. Nevertheless, the nurse was surprisingly unable to relate any conversations with the patient which resulted in a clear statement of the patient's preferences. Thus no one knew whether the patient desired aggressive treatment; neither were the patient's preferences regarding pain management known.

It would be all too easy to dismiss this as an atypical case because we live in a consumer-driven society where individual rights are so often accorded unquestioned supremacy. Disagreement between the family and health care providers over the aggressiveness of treatment and pain management, if not routine, at least occurs frequently enough to be of concern. Ideally *ethics places a check on the use of medical technologies and serves the gatekeeping function of not allowing any medical technology to be employed until the appropriate decision makers are identified and consulted.*

This bald statement seems obvious. It is not likely to be challenged by most health care professionals. Despite acknowledging the ethical significance of decisions by patients and families as well as professionals, it is still the case that health care professionals all too frequently fail to have conversations with patients about their treatment preferences until it is too late. Then they become embroiled with families, whose members are often conflicted, about what they deem to be the best course of action. By default, health care professionals may petition a court of law to appoint a guardian or proxy decision maker, hopeful, but by no means sure that the decision will concur with what the team believes is indicated.

Regarding the second question the nurse posed to the ethics review panel, let it be said that both these approaches, automatically deferring to the family and turning to the courts, are beset with difficulties. In spite of the caregivers' allowing the patient's family to assume the dominant role in decision-making, it is important to note that there are strong legal grounds for not automatically assuming that the family is the best surrogate for the patient.

When a patient is thought to be incapacitated to refuse treatment – or even to consent to treatment – it is a common mistake to suppose a family member may consent on behalf of the patient. In most states, the law *does not* permit family members – unless they have been legally authorized by court order granting guardianship to do so – to consent to or refuse medical care on behalf of an adult family member, incapacitated or not ([2], p. 82; italics original).

This legal position is consistent with the ethical principle of respect for persons.

### 2.1.2. *Decision-making Guides*

The ethical literature contains numerous guides for ethical decision-making. Here are highlights of four prominent examples.

1. *Pellegrino: 'Who Decides?'* [2,3]. Edmund Pellegrino recommends a three-pronged decision-making guide for competent, not competent, and variably competent patients.<sup>1</sup> If the patient is competent, the patient decides. The only limits to the patient's autonomy are that (1) the patient's action would involve harm to others, or (2) the action requires complicity from a health care professional which would violate the morals of the health care professional. If the patient was once competent but is no longer competent, ideally an anticipatory declaration (living will, durable power of attorney) exists specifying the patient's preferences. If the patient was never competent, a surrogate decides. A valid surrogate or proxy must (1) be competent, (2) know the patient and his or her values, (3) experience no conflict of interest, and (4) experience no serious emotional conflict.

2. *Jonsen et al.: Clinical Ethics* [4], further specify that if the patient has been able to express preferences in the past and has done so, the surrogate must use knowledge of these preferences in making the decision ("substituted judgment"). If the patient's own preferences are unknown or unclear, the proxy must then consider the "best interests" of the patient, using some more objective, socially shared values, such as relief of suffering, preservation or restoration of function, or extent and quality of life sustained ([4], p. 82). When a patient is variably competent the health care professional must act in accordance with the last competent decision.

3. *President's Commission: Making Health Care Decisions* [5]. Interestingly, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research rejected both the medical paternalism and patient sovereignty models of decision-making<sup>2</sup> and instead attempted to foster a "relationship between patients and professionals characterized by mutual participation and respect and by shared decisionmaking" ([5], p. 36). According to the Commission, the two central values in guiding decision-making in the provider-patient relationship are promotion of a patient's well-being and respect for a patient's self-determination ([5], pp. 41–51). These values will be explored in relation to this case later in this paper.

4. *Hastings Center: Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* [1]. More recently members of the Hastings Center task force preparing this report affirmed the value of patient autonomy or self-determination which establishes the right of the patient to

determine the nature of his or her own medical care. They also stated,

we place the patient at the center of the decisionmaking process ... A patient has decisionmaking capacity when the patient has (a) the ability to comprehend information relevant to the decision at hand, (b) the ability to deliberate in accordance with his or her own values and goals, and (c) the ability to communicate with caregivers ([1], p. 7).

In the case under consideration, pain, intravenous morphine administration, and possibly the effects of metastatic adenocarcinoma were interfering with the patient's ability to comprehend information, to deliberate in accordance with her values and goals, and to communicate with caregivers. Obviously her decision-making capacity was compromised. Sadly, the nurse presenting the case was unable to clearly state the patient's preferences when she was last competent. Failure to engage in advance planning by the caregivers with the patient denied them crucial information to guide subsequent critical care.

### *2.1.3. Planning in Advance for Critical Care*

Members of the interdisciplinary Geriatrics Section Ethics Committee of the William S. Middleton Memorial Veterans Administration Hospital, Madison, Wisconsin, recently published directives for planning in advance for critical care [6]. Their directives state that the intention of critical care planning is to ensure that the patient's rights are protected and the family's concerns respected whenever treatment decisions are made. This ethics committee gives this description of the critical care planning process: critical care planning allows patients, families, and health care professionals to discuss, clarify, and document their concerns, goals, and preferences for care in life-threatening situations before such emergencies arise. The learning is two-way. The patient and family are counseled about the patient's illness, treatment options, and possible outcomes (including death) with and without treatment, while the health care team gains insight into the patient's and family's perspective ([6], p. 37). They recommend documentation in the patient's chart of the patient's participation in these decisions and they call for this comprehensive format: (1) the planning session's date, time, and location; (2) the people who attended and any significant persons who were absent; (3) a statement about the patient's competence for critical care planning; (4) if the patient is not competent to plan, who planned for him or her and the basis for the decision made; (5) the patient's (and family's) attitudes, wishes, or concerns as discussed; (6) the person to be notified when death is imminent; (7) an interval of time to reevaluate the plan; and (8) if the patient has made a living will, where the document is filed.

Finally this ethics committee appeals to caregivers to seek further training to develop the listening, interviewing and counseling skills needed to do effective critical care planning and to seek consultation when necessary [6].

#### *2.1.4. Recommendation of the Ethics Review Panel Regarding Decision-making in this Case*

The panel recommended that caregivers evaluate the capacity of the patient to make decisions about further pain management strategies and additional treatment modalities. If the patient is assessed as lacking capacity to make this type of decision (decision-making capacity is not an all or nothing phenomenon) and there are no factors impairing decisional capacity which can be modified (effects of pain, effects of morphine, strong family pressure, desire to comply, etc.), then a conference should be scheduled with the health care team and family. The first goal of this meeting should be to determine if anyone present is able to accurately state the patient's last rationally stated preferences or produce appropriate documentation, such as a living will. If no one present can provide such information, the group should attempt to locate another surrogate decision maker who can. If the patient's wishes cannot be determined or other conflicts or interest disqualify a family member from serving effectively in this capacity, then as a last resort the health care team may need to request the court to appoint a proxy decision maker. Ideally, health care teams can learn by doing the value of advance planning. Then in future cases, when the progression of a disease makes a patient's decreased decisional capacity probable, they will anticipate the need to identify and clearly document that patient's preferences.

As we have seen, the nurse who made the presentation to the Ethics Review Panel raised three sets of questions. In the first set she wanted to know if the family's demands for their mother's wakefulness should override relief of her pain. She concluded by asking, "Do we have the right to increase sedation for her comfort when the family is not present?". So stated, her questions presume that the authority of the family to make treatment decisions is actually established merely by their demanding presence. Such is not the case. The first standard to be met by decisions on behalf of a decisionally impaired or incapacitated patient is substituted judgment, that is, decisions are consistent with the past expressed wishes of the patient herself when she had decisional capacity ([4], p. 82). It is not at all clear that the health care team in this case has definitively assessed this patient as lacking in decisional capacity. And, further, if this determination has been reached, we do not know if the family (or anyone else with appropriate first-hand knowledge of her preferences, such as a nurse or physician) has been asked to provide accurate information for the exercise of substituted judgment. We only know that they and an especially vocal daughter have been expressing *their own* preferences for their mother's care.

In her second set of questions, the nurse proceeded with the same presumption that the family had legitimate decision-making authority. She asked, "Is the stress of their mother's illness preventing the family from seeing her suffering?".

If, indeed, this patient was decisionally incapacitated and sufficient understanding of her own preferences on which to base substituted judgments was lacking, then it would follow that the capacity of the family to exercise judgments meeting the best interests standard ([4], p. 82) would be appropriate. As previously noted, decision makers who are incapacitated by emotional conflicts or other conflicts of interest may need to be disqualified. Only after it has been determined that the patient is decisionally incapacitated and that the family members are disqualified to exercise either substituted judgment or best interests judgment is it appropriate to petition a court of law for the appointment of a proxy decision maker.

In her third question, “Do we insist on having the patient included in meetings?”, the nurse needed to indicate that she suspected that the patient may have had some level of awareness, possibly decisional capacity. To the degree that this patient has any capacity, the nurse has the moral obligation to respect her autonomy. She needs to work to have the patient’s voice heard in staff/family discussions. No reasons were given by the nurse that would justify excluding a decisionally capable or even a variably capable patient from treatment discussions. But there is an even more fundamental ethical point which needed to be raised and was not. It concerns a decisionally capable patient’s right to confidentiality. If a patient has decisional capacity and if she wishes to exclude her family from the discussion of plans for her care, her right to confidentiality needs to be respected.

## *2.2. Patient Well-being vs. Patient Self-determination*

As noted earlier the President’s Commission identified patient well-being and respect for patient self-determination as the two central values which ought to guide decision-making in the provider-patient relationship. Ideally, both are simultaneously respected and served in each patient-provider interaction. In practice, however, a tension often exists between the two. Jameton captures this dilemma well when he queries, “Is it more important that patients choose what they want or that they get what they need?” ([7], p. 198). Jameton’s comment apparently assumes that health care professionals somehow both know and deliver exactly what patients need. This is certainly a questionable assumption. The President’s Commission wisely noted that ascertaining whether a particular health care intervention will, if successful, promote a patient’s well-being needs to be a matter of individual judgment. They cite the frequent absence of objective medical criteria specifying the best way to achieve a goal. They note the importance of the legitimate subjective preference of patients regarding definition of their own health and the importance accorded their health when ranked with other life values ([5], pp. 42–43).



In analyzing the case at hand the first task then is to identify what is genuinely in the patient's best interests. Furthermore, it should be noted that this determination to be 'genuine' requires taking into account the patient's subjective valuations, insofar as she has decisional capacity, lest her autonomy be violated. In making this determination we see clearly a second beneficial outcome ethical analysis secures for the use of medical technologies: *ethical analysis insists that medical technology be employed not merely on the basis of its being medically indicated, but rather on the basis of its ability to contribute to overall patient well-being*. One of the clearest explications of the complex notion of 'overall patient well-being' is made by Pellegrino and Thomasma [8]. They have developed a fourfold categorization of the patient's good along with a detailed discussion of procedures for reconciling conflicts which may occur when seeking to achieve it. The categories of 'good' are ranked in descending order of importance: (1) the last or ultimate good; (2) the good of the patient as a human person; (3) the patient's subjective best interest; and (4) the medical, biomedical, or clinical good ([8], pp. 81–82).

Thus, two distinct determinations should be applied to the case regarding the decision to employ both aggressive treatment modalities and select pain management strategies. These are (1) whether the intervention is medically indicated and (2) whether the proposed intervention advances the patient's overall well-being or 'good'.

### *2.2.1. Aggressive Medical Treatment of Metastatic Adenocarcinoma and Attendant Complications*

Jonsen, Siegler, and Winslade aptly summarize current medical thinking regarding inefficacious medical treatment claiming that there is no moral obligation to perform useless or futile actions: "Thus, if none of the goals of treatment is attainable, that treatment need not be initiated or continued" ([4], p. 27). They identify as appropriate medical goals: restoration of health, relief of symptoms, restoration of function or maintenance of compromised function, and saving or prolonging life.

Pellegrino bases his reasoning on a benefit/efficacy calculation which avoids the confusion engendered by the use of the popular but loaded terms "ordinary" and "extraordinary". If a treatment option is judged to be medically ineffective, and it is serving no larger patient benefit (e.g., prolonging life for some reason deemed important by the patient), then not only are there no moral grounds for implementing the treatment measures, but there may be grounds prohibiting their use. In the case in question, initiating a course of aggressive chemotherapy merely to satisfy the family in the absence of any determination of benefit to the patient would seem to be subject to moral censure [3].

Unfortunately in this case, the care providers have little information about the patient's perception of her ultimate goal or her subjective assessment of her best interests, i.e., the quality of life the interventions might produce. Compounding the problem is the difficulty identifying the interests from which family members are speaking. Clearly the nurse was unable/unwilling to grant that family members were speaking from their honest understanding of what their mother's preferences would be.

### *2.2.2. Recommendations of the Ethics Review Panel Regarding Further Use of Aggressive Treatment Modalities*

No additional treatment modalities viewed to be medically futile should be initiated unless a family member or court-appointed proxy is able to speak to their clear benefit for the patient.

### *2.2.3. Utilization of Intravenous Morphine to Keep the Patient 'Comfortable' via Maximal Sedation*

This section of the case analysis was the most troublesome for the ethics review panel because of doubts about the significance of the medical 'facts' used in the case presentation. The nurse, it will be remembered, claimed, "The patient was in excruciating pain throughout the hospitalization. She was placed on a morphine drip and the only time pain was absent was when she was fully sedated...". Hopefully this statement reflected the truth of the case rather than insufficient knowledge and employment of skilled pain management strategies. In most cases of cancer pain effective analgesia can be attained *without* 'snowing' patients and producing the effect which obviously distressed this patient's family. The ethics review panel clearly indicated the need to explore this situation and to evaluate the pain management program in place. This is a good illustration of an instance where accurate knowledge of the pertinent medical facts of a case may resolve the pseudo 'ethical' problem. For example, if the patient's pain could be managed without excessive sedation, seemingly the patient, the nurses, and the patient's family would all be happy. At issue is the level of sedation which was clearly unacceptable to the family yet viewed as the necessary means to the end of 'patient comfort' valued by the nurses.

To analyze this issue I will first explore the phenomenon of suffering and second apply two different models of autonomy from which one may arrive at distinctly different, yet ethically justifiable goals of patient care management.

*1. Phenomenon of suffering.* All who heard the nurse present this case were impressed by her overriding concern to be allowed to medicate this patient in order to alleviate her "excruciating suffering". Whether this concern is related to

the nurse's keen perception of and commitment to relief of suffering as one of nursing's key goals<sup>3</sup> or whether it reflects her inability to deal with human suffering and consequent need to eliminate its impositions on her is unclear. What must be clarified is the need caregivers have (1) to acknowledge that they and patients may view suffering differently and (2) to refrain from imposing their characteristic response to suffering on patients.

While most would agree that suffering is not an intrinsic good to be cultivated for its own sake, they are also in agreement that suffering is not ultimate evil needing to be abolished at any cost. Stanley Hauerwas [10] describes the constant temptation of health care professionals to try to eliminate suffering through the agency of medicine rather than to let medicine be the way we care for each other in our suffering.

Hauerwas challenges the nurse's unquestioned conviction that relief of the patient's suffering is to be sought at any cost.

In this brief reflection on suffering we see, then, another beneficial outcome ethics may secure when the employment of medical technologies is considered: *ethics challenges caregivers to reflect on the dynamic interplay between the caregiver's conscious and unconscious values and consequent determination of what is in the patient's best interests.*

We will turn now to an exploration of two contrasting models of autonomy.

2. *Two models of autonomy.*<sup>4</sup> It has often been noticed that a patient's competence is seldom questioned so long as the patient complies with the directives of the caregiver. It is thus not surprising that in this case the nurse seemed to sincerely believe that if the patient was free from her family's coercive influences she would choose complete pain relief since it was probably the only autonomous decision the nurse envisioned as realistic. By deciding for complete sedation the patient would affirm the nurse's own prior decision.

In the discussion that follows we will explore two distinct models of autonomy, the first is a model of *autonomous action* and the second is a model of *autonomous persons*. Each may result in different conclusions about what this patient might autonomously choose regarding pain relief and hence what the nurses' obligations should be. Given this distinction, what becomes immediately clear is a fourth beneficial outcome which ethics may secure when there is conflict about the use of select medical technologies: *ethical theory, carefully considered, provides a range of justifications for selected interventions (medical technologies) which makes possible rational dialogue between caregivers possessing different viewpoints about treatment options.*

The Faden-Beauchamp model of autonomous action identifies as the necessary, but not necessarily sufficient, conditions for autonomous action: "X acts autonomously only if X acts (1) intentionally, (2) with understanding, and (3) without controlling influences" ([11], p. 238). Thus Faden and Beauchamp

include as an indispensable criterion of autonomous action that the person be acting without undue controlling influences. Control is explicated in terms of coercion, manipulation, and persuasion. Clearly in this case the nurse believed that the only reason the patient might have for wanting the analgesic she was receiving to be decreased was to please her family who strongly desired that she be more alert. Using this model, the patient's desire to please her family may be seen as limiting her autonomy because the family was acting coercively, or, at the very least, strongly manipulatively. On this analysis, one reading of the obligation of the nurse would be to protect the patient's autonomy and to facilitate her autonomous decision-making by intervening to decrease the family's coercive influence.

The second model explored is the Dworkin model of autonomous persons [12].<sup>5</sup> What is most appealing in Dworkin's analysis, and has particular relevance for this case, is the notion that a person who wants to conduct his or her life in accordance with a goal such as "Do whatever my mother or leader tells me to do", or in our case, "Do whatever will best promote the well-being of my family", may be acting autonomously. On this analysis, if the patient decides that her personal well-being is secondary to the well-being of the family and feels prepared to accept some (or even a great) degree of pain and suffering in order to promote family harmony, then this *is* an autonomous decision and deserves to be respected as such. On this analysis the obligations of the nurse are to comply with the patient's decision to forego increased analgesia and to creatively work with the patient to employ other comfort measures which will not compromise the patient's state of alertness. Obviously other nursing obligations include continuing to assess family dynamics especially as they influence the well-being of the patient.

Given that the above models may lead to two different courses of nursing action with critical results for the well-being of the patient and family the importance of careful deliberation cannot be overemphasized. Obviously ethical theory serves a useful function in grounding decisions about the employment of select medical and nursing interventions.

#### *2.2.4. Recommendations of the Ethics Review Panel Regarding the Patient's Pain Management Program*

This recommendation is contingent upon the preceding identification of the appropriate decision maker. If the patient is clinically assessed to have decisional capacity, then the nurses' obligation is to respect her autonomous decision. Her choice might concur with the nurses' decision to keep her maximally sedated or it might conflict. The patient may wish to forego the intravenous morphine infusion entirely and rely on nonpharmacologic comfort

measures to stay alert. If she lacks decisional capacity and/or no one knows her analgesic preferences, then a designated proxy would need to determine what a reasonable person taking into account the patient's circumstances would consider to be in the patient's best interests. However, the possibility that this issue might be resolved if a level of analgesia is possible which effectively combats pain without compromising the patient's alertness is not to be overlooked.

### 3. CONCLUSION

In conclusion, this case analysis demonstrates that ethical analysis may lead to beneficial outcomes when medical technologies are employed. These outcomes include:

1. Not allowing any medical technologies to be employed until the appropriate decision makers are identified and consulted;
2. Insisting that medical technologies be employed not merely to promote the best medical interests of the patient, but rather on the basis of their ability to contribute to the overall well-being of the patient;
3. Challenging caregivers to reflect on the dynamic interplay between the caregivers' conscious and unconscious values and consequent determination of what is in the patient's best interests; and
4. Providing a justification for using selected interventions (medical technologies) which makes possible rational dialogue between caregivers espousing different viewpoints about treatment options.

### NOTES

<sup>1</sup> Further explication of this criteria may be found in [2] and [3].

<sup>2</sup> According to the President's Commission, medical paternalism is based on a traditional view of health professionals – typically physicians – as the dominant, authoritarian figure in the patient-professional relationship, with both the right and the responsibility to make decisions in the medical best interests of the patient. Conversely, proponents of maximal patient sovereignty assign patients full responsibility for and control over all decisions about their own care. According to this view, practitioners should act as servants of their patients, transmitting medical information and using their technical skills as the patient directs, without seeking to influence the patient's decisions, much less actually make them ([5], p. 36).

<sup>3</sup> Note that the International Council of Nurses Code for Nurses describes as the fourfold responsibility of nurses “to promote health, to prevent illness, to restore health, and to alleviate suffering” [9].

<sup>4</sup> For a more complete presentation of these theories the reader is referred to [11] and [12].

<sup>5</sup> It is significant that Dworkin designed this model specifically to resolve many of the

tensions and paradoxes inherent in the term “autonomy”. Among the tensions and paradoxes Dworkin identifies is that when the notion of ‘self determination’ is given a strong definition – the unchosen chooser, the uninfluenced influencer – it seems then that autonomy is impossible. Dworkin notes that there are conceptions of ‘autonomy’ which insist upon substantive independence. However, autonomy construed as demanding that the agent retain control over his decisions makes it inconsistent with other important values such as loyalty, objectivity, commitment, benevolence, and love.

#### REFERENCES

1. The Hastings Center. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Bloomington & Indianapolis, IN: Indiana University Press, 1987.
2. Pellegrino ED. The anatomy of clinical-ethical judgments in perinatology and neonatology: a substantive and procedural framework. *Semin Perinat* 1987;11(3):202–9.
3. Pellegrino ED. Withholding and withdrawing treatments: ethics at the bedside. In: Black P, ed. *Clinical Neurosurgery*, Vol 35. Baltimore, MD: Williams and Wilkins, 1989:164–84.
4. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 2nd ed. New York: Macmillan Publishing Company, 1986.
5. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Making Health Care Decisions*, Vol 1. Washington, DC: US Government Printing Office, 1982.
6. Streim JE, Siebers MJ, Hill SL, Bauwens SF, Meyer M, Vincent MO. Planning in advance for critical care. *Am J Nurs* 1989;89(1):37–41.
7. Jameton A. *Nursing Practice: The Ethical Issues*. Englewood Cliffs, NJ: Prentice-Hall, 1984.
8. Pellegrino ED, Thomasma DC. *For the Patient’s Good: The Restoration of Beneficence in Patient Care*. New York: Oxford University Press, 1988.
9. International Council of Nurses. *ICN Code for Nurses: Ethical Concepts Applied to Nursing*. Geneva: Imprimeries Populaires, 1973.
10. Hauerwas S. *Suffering Presence*. Notre Dame, IN: University of Notre Dame Press, 1986.
11. Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press, 1986.
12. Dworkin G. *The Theory and Practice of Autonomy*. New York: Cambridge University Press, 1988.