Ethical Issues and Decision Making for Respiratory Therapists

2nd Edition

By
Julio F. Turrens, PhD

Upon successful completion of this course, continuing education hours will be awarded as follows:
Respiratory Therapists: 2 Contact Hours

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Julio F. Turrens has disclosed that he has no significant financial or other conflicts of interest pertaining to this course book.

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ETHICAL ISSUES AND DECISION MAKING
FOR RESPIRATORY THERAPISTS

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A
Agree
Strongly

B
Agree
Somewhat

C
Disagree
Somewhat

D
Disagree
Strongly

OBJECTIVES: After completing this course, I am able to:
1. Describe the study of ethics and the main differences across various schools of ethical theories.
2. Recognize the principles that guide ethical decision making in the health professions as listed in the American Association for Respiratory Care Statement of Ethics and Professional Conduct.
3. Explain the ethical decision-making process within the professional healthcare setting.
4. Discuss approaches to clinical decision making using the SOAP method.
5. Describe professional codes of ethics and the legal implications and repercussions within the guiding rulings of health professions.

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7. The course content was presented in a fair, unbiased and balanced manner.
8. The course content presented current developments in the field.
9. The course was relevant to my professional practice or interests.
10. The final examination was at an appropriate level for the content of the course.
11. The course expanded my knowledge and enhanced my skills related to the subject matter.
12. I intend to apply the knowledge and skills I’ve learned to my practice.
   A. Yes   B. Unsure   C. No   D. Not Applicable

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   A. Poor   B. Below Average   C. Average   D. Good   E. Excellent

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1. Begin this course by taking the pretest. Circle the answers to the questions on this page, or write the answers on a separate sheet of paper. Do not log answers to the pretest questions on the FasTrax test sheet included with the course.

2. Compare your answers with the answers in the PRETEST KEY located at the end of the pretest. The pretest key indicates the page where the content of that question is discussed. Make note of the questions you missed, so that you can focus on those areas as you complete the course.

3. Read the entire course and complete the exam questions at the end of the course. Answers to the exam questions should be logged on the FasTrax test sheet included with the course.

Note: Choose the one option that BEST answers each question.

1. Utilitarianism defines morally acceptable conduct in terms of
   a. strict rules.
   b. consequences.
   c. ideal values.
   d. rules that all must agree upon.

2. The principle of “beneficence” states that
   a. the healthcare professional should ensure the patient does not experience pain.
   b. the actions of the healthcare professional are guided by what is in the best interest of the patient.
   c. the healthcare professional must make donations to charitable organizations.
   d. the healthcare professional must “do no harm.”

3. The first thing to do when confronted with an ethical dilemma is
   a. ponder the consequences of my actions.
   b. determine which school of ethics could better guide me in my decision making.
   c. gather all relevant data concerning the issue.
   d. look at similar cases and how they were addressed.

4. If a terminally ill patient asks for assistance ending their life, as a health practitioner you should:
   a. try to counsel them concerning their wishes.
   b. ask their preferred method for ending their life.
   c. contact their physician and have him/her decide on the best practical approach.
   d. intervene with their regular prescription use.

5. Mapping out a detailed schematic outline used to accomplish a goal is what part of the SOAP process?
   a. Subjective
   b. Assessment
   c. Plan
   d. Objective

PRETEST KEY
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INTRODUCTION

COURSE OBJECTIVES

After completing this course, the learner will be able to:

1. Describe the study of ethics and the main differences across various schools of ethical theories.
2. Recognize the principles that guide ethical decision making in the health professions as listed in the American Association for Respiratory Care Statement of Ethics and Professional Conduct.
3. Explain the ethical decision-making process within the professional healthcare setting.
4. Discuss approaches to clinical decision making using the SOAP method.
5. Describe professional codes of ethics and the legal implications and repercussions within the guiding rulings of health professions.

This advanced level course covers the essential ethical principles for respiratory therapists and other healthcare providers. The contents of this course include many ethical issues that respiratory therapists and others may encounter in patient care settings. Additional contents include discussions on professional moral dilemmas, ethical theories (e.g., utilitarianism, deontologic ethics (Kantianism), social contract theory, virtue ethics). Examples are used to illustrate principles that guide ethical decision making. Case studies are used throughout this course to reinforce understanding and learning of the essential ethical principles.

A community can only prosper if its members follow values and principles to guide them in behaviors that are good and proper. Ethical values direct us in our everyday lives because they are ingrained in our society. Given the scope of their disciplines, healthcare professionals must frequently make decisions based on ethical and legal issues. Therefore, it is important to learn the ethical principles, professional codes of ethics, and legal aspects that guide the profession, so that we can be knowledgeable about ethical decision making when dilemmas arise.

Health professionals have always been concerned with assuring that their responsibilities are carried out in an ethical way, with the outmost concern for the well-being of their patients. One of the earliest documents that describes the professional expectations of physicians, the Hippocratic oath, was probably developed about 25 centuries ago (Davey, 2001). Despite this, unethical behavior in the health professions has not been rooted out. From human experimentation on prisoners in concentration camps during World War II (Annas & Grodin, 1995) to the infamous Tuskegee Syphilis Study in the United States (Brandt, 1978, discussed later), human history is plagued with examples of unethical conduct. These atrocities led to the development of several important documents that aimed at better defining...
the ethical principles behind human studies. However, in addition to being aware of regulations in their field, it is important that all health professionals develop a sense of what is morally acceptable.

Each day, healthcare professionals make ethical decisions in the performance of their regular duties, some of which may have legal implications. For example, a clinician receives a heavier workload than normal due to a staffing shortage on the shift. The problem is further compounded by several time-consuming emergencies that arise during the shift, resulting in the clinician requesting help from coworkers and supervisors to help prioritize the workload. While prioritizing, scheduled routine treatments for two patients are delayed for several hours. This is an ethical dilemma that could become a legal matter if one of the patients whose treatment was delayed develops minor or major complications attributable to the delay.

Ethical decisions in the health professions may also involve decisions without a direct impact on patient health but may instead relate to professional conduct, such as respecting patient privacy by refraining from discussing a case in public places (e.g., elevators, during lunch, on social media). In modern society – particularly among the health professions – ethics and the professional codes of ethics can guide us in performing our duties with professionalism and in a way that is legally appropriate.
ETHICAL ISSUES AND DECISION MAKING FOR RESPIRATORY THERAPISTS

MORALITY AND ETHICS

Ethics, or moral philosophy, is concerned with studying what is right or wrong in human conduct and how we can live in peace and harmony. It is a branch of philosophy devoted to understanding and explaining the standards of conduct and moral judgment (Beauchamp & Childress, 2013; Purtilo & Doherty, 2011). In common usage, the terms ethics and moral philosophy are used as synonyms. The study of ethics includes the systematic study of rules of conduct because they are grounded in philosophical principles and theory. The field of ethics encompasses two main areas: normative ethics and metaethics. Normative ethics is the study of rules (norms) that determine what actions are right or wrong (Beauchamp & Childress, 2013; Purtilo & Doherty, 2011; Solomon, 1995). Metaethics investigates the nature of ethical judgments, including what ethical statements mean and how we may know they are true (Beauchamp & Childress, 2013). Normative ethics addresses concrete or everyday problems of ethical action, while metaethics studies the abstract or theoretic aspects of ethical reasoning. The American Association for Respiratory Care (AARC) Statement of Ethics and Professionalism outlined later in this course includes both analyses of everyday decision making (normative ethics) and the theoretic principles (metaethics; AARC, 2012).

Ethics involves the systematic study of and reflection on morality. The understanding of ethics is derived from human interactions and other aspects of human life. Therefore, our understanding of ethical behavior is a dynamic and evolving process. Although the basic principles of ethics remain stable, our understanding of morality changes as events and innovations create new situations, causing us to reorganize our thinking, alter our behavior to address new issues, or both. One example is the development of social media on the Internet. For example, can a respiratory care professional (RCP) implement an individualized respiratory care plan for a particular patient via social media while still protecting the patient’s right to privacy and confidentiality?

Because society may change its ideas over time about morality and about which moral actions are considered right or wrong under different circumstances, any code of ethics must be revised periodically to reflect these changing ideas. For example, agreeing to suspend life support in terminal cases is currently considered an acceptable procedure, but it could have been considered a criminal action before 1968. These standards changed after an ad-hoc committee at Harvard proposed a new definition for death (JAMA, 1968). The current American Association for Respiratory Care (AARC) Statement of Ethics and Professional Conduct (2015) reflects modern day thinking; however, these principles and way of thinking may be
reevaluated and revised on a regular basis. Such updates are designed to improve the quality of care that RCPs provide to patients and to ensure that knowledge, skills, and attitudes in the field of respiratory care are applied within the ethics standards adopted by society as reflected in current state and federal laws and regulations as well as institutional policies and procedures.

**THEORIES IN ETHICS**

Several theories, also known as schools of thought, in normative ethics try to set the principles and rules behind moral behavior (Purtilo & Doherty, 2011; Rachels & Rachels, 2012). This section briefly discusses several widely accepted theories, including deontological ethical theories (Kantianism), consequentialist ethical theories (utilitarianism), social contract ethical theory, and virtue ethics. Two of them – Kantianism and utilitarianism – are the most prevalent in the ethics literature (Solomon, 1995).

**Deontological**

The word *deontologic* is from the Greek *deon*, meaning duty or obligation. Deontological theories are based on the concept of duties. The most famous proponent of deontology was the 18th-century German philosopher Immanuel Kant (Rachels & Rachels, 2012), who originated the idea of a categorical imperative as the guiding rule behind ethical decision making. In general, an imperative is a command, but Kant used the notion of an imperative more specifically to mean a *command of reason* – something reason requires us to do. Imperatives, Kant argued, come in two forms, hypothetical and categorical (Kant, 1990, p. 31; Rachels & Rachels, 2012). A hypothetical imperative states what is required by reason to get some other end that we want. For example, if a person wants a university degree, then reason tells that person to enroll in a university and study – this is a hypothetical imperative. All hypothetical imperatives can be expressed as conditionals, also known as “if … then …” statements. By contrast, categorical imperatives are not expressed as conditionals, but instead they command us to do something categorically, universally, and in every situation, regardless of the goals or ends. In this regard, Kant stated, “Act only according to that maxim by which you can, at the same time, will that it should become a universal law” (Kant, 1990, p. 38).

However, at least one thing is unconditionally valuable, Kant believed, and that is a person. Kant calls people “ends in themselves” or “intrinsically valuable” (Kant, 1990, p. 45-46; Rachels & Rachels, 2012). Kant proposed that it is morally wrong to treat someone as a mere means, which occurs when we treat a human in a way that he or she does not – or could not – rationally agree with us. For instance, slavery is intrinsically wrong because a person could not rationally agree to being enslaved. However, to treat a person as a servant in a mutually agreed upon economic arrangement is not to treat him or her as a mere means, because the other party has rationally agreed to the arrangement. This latter example treats the person as a means but not a mere means; therefore, the agreement is morally permissible from Kant’s view.

In a professional setting, for example, the individual (e.g., healthcare professional, educator, researcher) has a duty to protect and fulfill another person’s (e.g., patient, client, student, research volunteer) needs and rights. Decisions are made based on those needs and rights without regard for the consequences of actions. Likewise, a patient has a right to autonomy and privacy (see later), which the healthcare professional has a duty to respect. Under deontological theory, these are always primary duties, and other considerations – such as whether an RCP likes the patient or whether the patient has good moral character – are subordinate to duty.
Consequentialist

Consequentialist ethical theories, sometimes called teleological theories (from the Greek word *telos*, meaning *end*), do not focus on duties but rather on the consequences or ends of our actions as the measuring tool to determine whether an action is morally acceptable. Utilitarianism is the most famous consequentialist theory. It was first described by Jeremy Bentham in the 18th century and later by his disciple John Stuart Mill in the 19th century (Bentham, 2010, Mill, 2013). They proposed that the correct action is that which maximizes happiness (Rachels & Rachels, 2012). Utilitarians argue that ethical decisions should be guided by what benefits the most. Bentham says: “Nature has placed man under the governance of two sovereign masters: pain and pleasure,” and later he indicates that the principle of utility “approves or disapproves of every action whatsoever according to the tendency it appears to have to augment or diminish happiness” or “in other words, to promote or oppose that happiness” (Bentham, 2010). Mill also refers to greatest happiness. In his book, *Utilitarianism*, Mill says: “Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness” (Mill, 2013).

Incidentally, notice that the term *happiness* also appears in the preamble to the Declaration of Independence (1776), which states that all citizens are entitled to rights that include life, liberty, and the pursuit of happiness.

Here the phrase *actions or rules* points at another distinction. Some utilitarians are *act* utilitarians, while others are *rule* utilitarians. Act utilitarians seek to maximize the utility of each action; by contrast, rule utilitarians hold that the rules should be adopted – broadly construed to include both moral rules and laws – that maximize utility. For instance, we may argue that the quality of education should be independent of the financial resources available to every school district.

From the standpoint of a utilitarian, if two treatment techniques have been proven to be equally effective, then the healthcare professional should consider the consequences: Which technique will bring the most benefit? Which one will provide the best outcome for the patient based on his or her situation?

In summary, utilitarian consequentialism and Kantian deontological ethics are distinct. Utilitarians emphasize the tendency of an act or rule to produce a certain outcome, while Kantians focus not on outcomes but on categorical duties. However, in many cases these two theories reach the same conclusion. For example, teaching a patient how to prevent asthma attacks (the *duty* to prevent harm) coincides with the warning that exposure to an allergen will cause the patient to have an attack (*consequence*).

But, at other times, these two theories may yield different results. One such case might be a situation in which an RCP is considering whether it is permissible to tell a patient a “white lie.” For example, perhaps the RCP thinks informing an already traumatized patient of the exact severity of the injury might do harm to the patient. The RCP might be concerned that the psychological shock of the information could worsen the patient’s condition. Is it morally permissible to lie in this case? In this scenario, Kantians and utilitarians may disagree. Subscribing to the Kantian theory means we must treat patients as ends in themselves, not mere means, so we are instructed to be truthful, because the patient cannot rationally consent to the RCP lying to him or her. However, for the utilitarian, the fact that the RCP might increase the patient’s suffering by telling him or her the truth could justify the RCP’s decision to tell a white lie – at least in these extraordinary circumstances – because such a lie would maximize utility.
Social Contract

Multiple sources of information can provide multiple answers to the same question. As a result, a single person or group must make a decision regarding what actions are acceptable, when, and in what situations. Laws, rules, regulations, and policies often are designed for the betterment of the entire community. This is the basis of a third ethical theory known as the social contract, which was first proposed in 1651 by Thomas Hobbes (who also used the term “covenant”; Hobbes, 2013) and later by Jean Jacques Rousseau in his book, On The Social Contract, published in 1762 (Rousseau, 2003).

Social contract theory seeks to provide an account of the legitimacy of the state and of the nature of our political obligations. Rousseau developed this idea of consent into his notion of the “general will.” The general will expresses the collective interest, the will of all, including the sum of all private wills and is never wrong. Rousseau states: “I hold then that Sovereignty, being nothing less than the exercise of the general will, can never be alienated, and that the Sovereign, who is no less than a collective being, cannot be represented except by himself: the power indeed may be transmitted, but not the will” (Rousseau, 2003).

For example, a RCP might join an association like the AARC, which expresses the general will of its members by embodying the shared interests of those other professionals in the respiratory care profession. It impartially represents all such interests. In a like manner, the state impartially represents the interests of all of its citizens, deriving its legitimacy from the general will that it expresses.

However, good intentions sometimes can get lost in bad laws. For example, the Eighteenth Amendment was ratified by Congress in 1919, which prohibited liquor from being manufactured, sold, or transported within the United States. This legislation was designed to save individuals from destructive and reckless behavior by removing the temptation to drink liquor. Part of the rationale was that the behavior caused by alcoholism would destroy families, especially when the father became an alcoholic and was unable to earn money to support his family or had spent all his earnings on liquor. According to the amendment’s proponents, including the Women’s Christian Temperance Union, families and society would be better off without liquor. However, the framers of the law disregarded the social aspect of liquor in American culture. Despite the amendment, liquor continued to be illegally manufactured (bootleg liquor) and social clubs (speakeasies) continued to serve liquor until Americans recognized that outlawing liquor was not an effective means of solving the dilemma of families losing their breadwinner to alcohol. In 1933, the Twenty-first Amendment repealed the Eighteenth Amendment. The lesson is that laws, rules, regulations, and policies must be carefully considered and periodically reevaluated to determine whether the intended objective is being met in the best possible manner. According to the social contract, ethics and ethical behavior likewise must be periodically reexamined to assess what is being accomplished and whether a better approach is needed to solve the identified problem.

Virtue Ethics

For many centuries, our civilization has been concerned with what constitutes a virtue and what makes a person “virtuous.” Greek philosophers explored these ideas, particularly Aristotle in the third century BCE. According to the theory of virtue ethics, the process of ethical decision making revolves around the question, “What would a virtuous person do in this situation”? This thought process is founded in personal attributes of character and virtues (e.g., altruism, trustworthiness, empathy,
responsibility). Decisions are mainly based on the actions of previous practitioners who have distinguished themselves as being virtuous and have become role models. The established practices of the profession also provide guidance in decision making, and the virtue ethicist upholds the traditions set forth. Each question is answered by envisioning what a morally good and virtuous practitioner did – or would do – in a similar situation.

Thus, according to virtue ethics, the moral value of an action is at least partly a function of the character of the agent or agents involved in the action. As a result, compared with other ethical theories, virtue ethics typically places more emphasis on the particular specifics of an action, because something must be known about the character of the actors prior to making a moral judgment about their action. This has led to some criticism of virtue ethics on the grounds that it fails to provide sufficiently general moral guidance to help us to resolve moral dilemmas. For example, both Kantianism and utilitarianism can offer moral guidance with respect to the moral dilemmas surrounding an issue such as active euthanasia. For even if these two theories do not always agree, they at least allow us to determine what is morally most important: Is it treating others as ends in themselves, or is it seeking to maximize utility? By contrast, virtue ethics seems to offer little guidance in this type of case, because we are required to know something about the character of the individuals involved in a particular situation of active euthanasia, or so the objection goes. The ever-changing healthcare field, along with technological advances in health care and changing moral values, sometimes make previous decisions incorrect and leave little room for creative decision making. In addition, if a comparable virtuous example does not exist, then we are left with the problem of having inadequate answers to difficult situations. The healthcare professional may be unable to envision the proper course of action without a virtuous example to follow.

Other Theories

With regard to the four theories previously discussed, some of them have evolved into less strict forms. For example, rule utilitarianism is a variation of consequentialism that moves away from decision making based on the utility of particular actions to instead favor a focus on the utility of rules. In this case, the thought process is based on choosing the rules and principles that will produce the most good. In this sense, rule utilitarianism moves in the direction of deontological theories, which are also rule based. However, it is important to remember that the moral legitimacy of the rules – what grants them their moral authority – remains wholly different between these two views. For rule utilitarians, the moral legitimacy of rules derives from their ability to maximize utility. For deontological theorists such as Kant, it derives from universal commands of reason.

Other ideas about what constitutes ethical behavior and provides methods to solve ethical dilemmas come from multiple sources, such as social norms, authority figures, religious orientations, traditional wisdom, and contemporary culture (Rachels & Rachels, 2012). Social norms guide action by example – traditional wisdom is transmitted by elders who are assumed to know how to best handle and how to best act in various situations (i.e., this is how we do it). The behavior is built into a ritual or routine. The rationale for the action may be lost over time, but the behavior may remain intact. Authority figures state what is to be done by saying, in one form or another, “because I said so” or “this is the way we have always done it.”

Religions often provide guidelines for ethical behavior through teachings handed down
over many years. The natural law ethical theory was developed by early Greek philosophers and is based on the idea that everything has a reason for its existence – a rational purpose (Rachels & Rachels, 2012). According to Aristotle, man was supposed to identify these purposes. During the Middle Ages, St. Thomas Aquinas, among other Christian thinkers, believed that moral laws or standards were derived from nature. An example of such a natural ethical law might be rooted in the idea that, because we tend by nature to grow and mature (a natural function), we morally ought to seek to preserve our health and welfare by avoiding dangerous things. Still another kind of ethical theory is called divine command ethical theory, which claims that what makes something right or wrong is the command of a divinity such as the Christian God. For example, if God commands something, then it is morally obligatory solely because God commands it. Likewise, according to the theory, if God proscribes something, then it is prohibited simply for the reason that He disallows it.

Although ethics in the United States has been strongly influenced by the Judeo-Christian religions and traditions, few ethicists today espouse either natural law ethical theory or divine command ethical theory. One reason for this is that both theories are subject to numerous objections. For instance, the philosopher Plato identified an important problem with divine command theories more than 2000 years ago. In his dialogue, Euthyphro, Plato argued that divine command theories misidentify the locus of moral value. To determine why, consider an intuitively morally wrong action such as murder. Murder, which is premeditated and unjustified homicide, seems to be wrong in itself, or simply because of its nature, as opposed to being wrong because a divine being says it is wrong, as divine command ethical theorists assert. Another obvious challenge for this type of view is that no consensus exists on what, if anything, ought to count as a divinity. For example, Muslim, Hindu, Taoist, and Christian notions of God all vary, as do many of their ethical directives. From an ethical standpoint, religious traditions have major limitations because what is acceptable in one religious tradition may not be acceptable in others.

Finally, contemporary culture conveys popular wisdom through phrases like, “What would your mother say?” and “Go with your gut.” However, these approaches lack the rigor expected from more formal theories; therefore, they have only limited value.

**ETHICAL PRINCIPLES IN HEALTH PROFESSIONS**

Ethical theories provide the foundation for morally sound behavior, and they usually provide the basis for ethical decision making. However, healthcare professionals often confront ethical dilemmas that cannot be solved by simply adopting an established theory but rather require clear rules based on defined bioethical principles. For example, one may imagine many situations in which a health professional needs to choose among clinical options that may have opposite effects on the patient in terms of quality of life, pain, prolonging life, and healing process, among other factors. In cases like this, it is useful to have clear guiding principles.

From a historical standpoint, most of these guidelines were developed in response to specific unethical events. For example, the Nuremberg Code was written in 1947 after the Nuremberg war crimes trials in which Nazi officers and doctors were convicted of crimes against humanity for experimenting on humans held in concentration camps without their consent. The code introduced for the first time the concept of informed consent (Annas &
Likewise, in 1974, following the Tuskegee Syphilis Study (Brandt, 1978) Congress established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which in 1978 issued a report entitled *Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. This document, known as the *Belmont Report* (*Belmont Report*, 1979), established the basic ethical principles that guide human research studies, including beneficence, respect for persons, and justice.

Ethical principles in the health professions include professional duties and patient rights, and provide the foundation for ethical decision making to help professionals when confronting an ethical dilemma. Some of the guiding principles include autonomy, veracity, nonmaleficence, beneficence, confidentiality, justice, role fidelity, and respect for human dignity. Each of these principles is described as it pertains to adult, alert, and oriented patients capable of making their own decisions, or to a healthcare proxy (a person with power of attorney) if the patient is incapable of decision making, and to the parents or guardians of pediatric patients. All the following principles must be weighed and balanced with each other, as well as with the law, to achieve the best possible outcome for each situation. The following paragraphs discuss some of the principles described in these documents as well as other important principles derived from them.

**Autonomy**

The principle of autonomy (respect for persons) is recognized by all ethical theories. For example, Kant indicated that all persons are ends in themselves because they are autonomous agents. Utilitarians like Mill argued that overall utility would also be maximized if people were allowed to act as autonomous agents. Mill argued that if each individual was left free to pursue his or her own happiness, then the happiness of all would be maximized, provided that one person’s pursuit of happiness did not interfere with the pursuits of others. Virtue ethicists would argue that we should respect the right of an individual to make his or her decisions out of our respect for others.

Autonomy obligates healthcare professionals to grant to others the freedom of will and the freedom of action. This principle allows an autonomous patient the personal liberty to participate in an experimental study or make decisions about his or her own course of treatment and options.

In some cases, patients may have limited autonomy and be unable to understand or give consent. These individuals are considered to be members of a vulnerable population, and, in this case, another individual must take responsibility and make decisions for the patient (e.g., parent, court-appointed guardian). Examples of vulnerable populations include: minors, the mentally ill, prisoners, and any other group whose decision power may be limited or questionable.

The Nuremberg Code is widely accepted as one of the landmark documents underscoring the principle of autonomy. It sets many of the standards that protect the autonomy of patients participating in research studies. For example, the Code establishes that participants in scientific experiments must be fully informed of all details before they agree to participate in a study. Once they agree and sign an informed consent form, they retain the right to refuse to continue the study if they choose.

Informed consent forms are used both in research and for medical treatment. In the latter case, the patient must sign the consent prior to a procedure to acknowledge agreement and consent (Corning, n.d.; Figure 1). The patient has the right to be given complete, accurate, and comprehensible information so that he or she
can assess the risks and benefits of any available options in his or her healthcare plan. With regard to research protocols, the patient has the right to accept, refuse, or terminate treatment without deceit, duress, coercion, or penalty. It is both unethical and illegal to use coercion or deceit to prompt a reversal of decisions. Informed consent forms are signed and dated by a healthcare professional, the patient or surrogate, and a witness. Many consent forms add entries for patient acknowledgment about the disposal of body tissue according to institutional policy, consent for obtaining pictures or videos during the procedure (with identity hidden) for the advancement and dissemination of medical and scientific knowledge, and instructions regarding removable prosthetic implants.

In situations where the patient is a minor or otherwise lacks the capacity to make informed decisions (vulnerable populations), the role of the parent/guardian is to make decisions as the patient would, based on the patient’s previously expressed wishes, known values, or both (advance directives). In the absence of a designated surrogate decision maker, decisions must be made in the best interest of the patient.

Out of respect of the patient’s autonomy, the healthcare professional must grant patients the right to refuse medications, therapies, surgery, and any other procedures.

Veracity

Veracity is closely related to autonomy. This principle binds the healthcare professional and the patient and instructs them to be truthful with each other, mutually sharing all pertinent information. Veracity also obligates the healthcare professional to perform complete and accurate charting in the medical records.

In the following example, an RCP debates whether she should compromise this principle to help her coworkers. The RCP attended a meeting in which her supervisor stated that the staff would be downsized in the near future. The reason given for lower staffing levels was that the therapist-driven protocol (TDP) implemented at the hospital 2 years ago has been very successful and eliminated a large amount

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**FIGURE 1: EXAMPLE OF INFORMED CONSENT FORM**

<table>
<thead>
<tr>
<th>Patient’s name: ___________________________</th>
<th>Date: ___________________________</th>
</tr>
</thead>
</table>

**Patient’s statement:**

I consent to the following procedure ______________ (type of procedure). I understand the nature and purpose of this procedure as explained by my physician, ______________________ (name of physician). I have been made aware of the substantial risks (describe in detail) and hazards (describe in detail) of this procedure. Medically acceptable alternatives have been explained to me. I have had the opportunity to ask questions, and I have had them answered to my satisfaction.

**Patient’s signature ___________________________**

**Witness ___________________________**

*Note. Adapted from Western Schools. Copyright 2018.*
of unnecessary respiratory therapy. By freeing RCPs from performing unnecessary therapy, the TDP has also successfully implemented an efficient and cost-effective realignment of respiratory resources toward the areas of care where help is needed most (e.g., critical care). Judy, who is the TDP evaluator, begins to wonder whether she should help her fellow coworkers keep their jobs by being less efficient; perhaps she should keep patients on therapy a little longer. She also wonders whether she should not eliminate or decrease therapy so quickly. Although this could be a dilemma for the healthcare professional, it is ethically and legally permissible to continue the successful TDP. Judy concludes that she must properly document in the patient’s medical record whenever a need exists to reduce or eliminate respiratory treatments according to the TDP.

Sometimes a healthcare professional may face an ethical dilemma when his or her obligation to be truthful to the patient may have a negative impact on the patient’s well-being. In such circumstances, the professional may consider using benevolent deception as a solution to the problem by withholding information “for the patient’s own good.” In this scenario, the healthcare professional often has good intentions (e.g., protecting the patient from emotional and mental stress). However, aside from pediatric patients and in cases of suicide prevention, it is usually recommended to share all information with the patient and avoid deception. This is consistent to Kant’s ethical theory, which proposes that even seemingly harmless lies are morally impermissible if the person being lied to could not rationally consent to being deceived.

The following is an example of benevolent deception: A 45-year-old man is admitted to the hospital with terminal lung cancer. He is very distressed. As the RCP adjusts the ventilator, she tells the patient that he should be in good spirits because she has seen substantial improvements in other patients in similar situations, even though the RCP knows that the patient is terminally ill. The RCP thinks that this statement will improve the patient’s attitude, when, in reality, the situation may have been better had she said nothing at all.

As previously mentioned, benevolent deception is strongly discouraged as it violates the principle of veracity. In addition to the fact that one is hiding information from the patient, this behavior may lead to the patient losing trust in the treating professional. For example, the patient in this example may find out that the suggested approach (adjusting the ventilator) does not have anything to do with improving his terminal condition and may feel betrayed.

**Nonmaleficence**

Nonmaleficence obligates the healthcare professional to prevent and avoid harming the patient. This principle is sometimes difficult to uphold due to inadvertent adverse events of some drugs and procedures that are therapeutic to the patient. The risks and benefits must be weighed and balanced to determine the best course of care for every situation. Normally, if the best possible therapy for the patient is provided, the adverse side events are viewed as involuntary and unintentional and the decision does not violate the principle of nonmaleficence. For example, Sarah is a terminally ill patient with cancer who is experiencing an increase in pain despite being given high doses of morphine. Sarah has asked her clinician for more pain relief. However, increasing the morphine dose may lead to respiratory depression or cause respiratory arrest. The treating clinician decides to increase the dose of morphine because in his view, it is more important to palliate Sarah’s pain.
Beneficence

Beneficence obligates the healthcare professional to actively promote and contribute to the health and well-being of the patient. Many quality-of-life issues arise while adhering to this principle. Modern medicine possesses the capability to prolong a person’s life beyond the likelihood of any meaningful recovery. The patient’s quality of life during and after an illness is an important consideration in these situations, presenting the healthcare professional with the dilemma of whether it is best to prolong life regardless of any other circumstances, to provide comfort measures alone, or to not perform “heroic” measures to prevent or delay death. In the previous example of Sarah, the decision to increase the dose of morphine is based on this principle, despite knowing that the treatment may precipitate Sarah’s death, because the ultimate goal of the clinician was to help Sarah feel better. The reader should be able to see the ethical conflict between the assumptions that the clinician’s duty is to prolong life compared with what may be in the best interest of the patient (palliate discomfort).

Confidentiality

The patient has a right to privacy, and healthcare professionals have a duty to maintain confidentiality of all patient information. The patient’s well-being could be jeopardized and the fundamental trust between patients and healthcare professionals destroyed by unnecessary access to data or by inappropriate disclosure of patient information. To provide quality health care, it is necessary to share relevant data with those members of the healthcare team who have a need to know. Only information pertinent to the patient’s treatment and welfare should be disclosed, and that information must be disclosed only to those directly involved with the patient’s care. Duties of confidentiality do have exceptions and may need to be modified to protect the patient and other innocent parties, when required by law to provide information, and in cases of mandatory disclosure for public health reasons. Information can also be used for purposes such as quality improvement, peer review, or insurance payments, but only according to established policies.

The U.S. federal government signed into law the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which, among other things, protects the patient from breaches in confidentiality and unauthorized disclosure of identifiable patient information.

Justice

The principle of justice is one of the three pillars of the *Belmont Report*, which provides the guidelines for human studies (*Belmont Report*, 1979), by stating that people must be fairly treated. For example, a study cannot involve volunteers from a group who will not have access to the benefits of said study if those benefits became available.

Other issues related to justice include the concept of *distributive justice*. How do we make decisions involving expensive medical treatments to people covered by Medicare and Medicaid? How do we set priorities for funding by the National Institutes of Health (e.g., funds allocated for cancer research vs. infectious diseases)?

Role Fidelity

Role fidelity is a principle wherein healthcare professionals understand the limits of their professional responsibilities and act only within their scope of practice. The licensure board and the healthcare institution set forth the scope of practice. Healthcare professionals must have competence in performing all duties assigned to them, and they must not perform duties outside their scope of practice. This principle also