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Ethics for Healthcare Professionals

2.00 Contact Hours

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Outcomes

≥ 92% of participants will be able to apply ethical principles in decision-making.

Objectives

Upon completion of this course, the participant will be able to achieve the following objectives:

1. Define four ethical principles commonly affecting healthcare professionals.
2. Relate four causes of ethical dilemmas for healthcare professionals.
3. Describe theories of ethical decision-making.
4. Differentiate between capacity and competency when assessing an individual's decision-making capacity.
5. Outline three benefits of advanced care planning

Introduction

What are ethics?

The concept of ethics began with the introduction of moral codes into the realm of human existence. Ethics comes from the Greek word "ethos," which represents character. Ancient Greece is considered the birthplace of Western theoretical ethics. Socrates, who is viewed as one of the foremost teachers of ethics, declared that "the unexamined life is not worth living."

The writings of the 19th-century German philosopher Immanuel Kant played a key role in shaping society's understanding of ethics. He espoused the belief that rational actions cannot be founded on personal desires but must agree with collective norms. Since the start of the 20th century, emphasis has been given to applying ethics to everyday problems (Singer, 2023).

Is there a difference between personal and professional ethics?

Our world is changing and evolving, and often, there are no simple "right" and "wrong" answers, which often places us as individuals and as organizations in ethical dilemmas. As Susan Liataud points out, "everything you do matters," and each of us lives with the consequences of our actions (Liataud & Sweetingham, 2021).

Personal ethics are our beliefs about what constitutes right and wrong and guide our actions. Personal ethics are used in decision-making in private life and the professional realm. Having a strong core of personal ethics influences our professional lives in several ways, such as setting a standard of behavior, enhancing decision-making ability, and allowing those in leadership positions to be more effective in their roles. The main difference between personal and professional ethics is that while personal ethics speaks to beliefs applicable in all aspects of

life, professional ethics denotes values that must be adhered to within the work setting (Glassdoor, 2021).

Healthcare Professionals' Responsibilities

Healthcare professionals are in a trusted position but are also human. That is why healthcare professionals must be able to promptly and fully self-disclose facts, circumstances, events, errors, and omissions when such disclosure could enhance the health status of patients or the public or protect patients or the public from unnecessary risk of harm.

Healthcare professionals have a duty to the patient. That is the highest level of responsibility. Employers, other team members, and healthcare professionals' interests do not outweigh this fundamental responsibility. Healthcare professionals must be aware of their actions and feelings within the therapeutic relationship, identify the invisible boundaries, and act in the patient's best interest.

Healthcare professionals are in a position of power. It is important to practice in an autonomous role with patients, their families, significant others, and members of the public during difficult times in their lives. Healthcare professionals are in a position to take advantage of vulnerable people and should avoid any abuse of trust.

A healthcare professional has a vital role in maintaining professional boundaries and must be able to know, recognize, and maintain the professional boundaries of the healthcare professional-patient relationship. Violating the professional boundaries of the healthcare professional-patient relationship includes, but is not limited to, physical, sexual, emotional, or financial exploitation of the patient or the patient's significant other.

Healthcare providers in multiple disciplines can turn to professional organizations to guide ethical decision-making in their respective roles. The American Medical Association Code of Medical Ethics provides advice on such topics as patient rights, ending the patient-physician relationship, physician exercise of conscience, and ethical practices in telemedicine (American Medical Association, 2017).

The American Nurses Association Code of Ethics, last revised in 2015, lists nine requirements. The first is that nurses must practice with compassion and respect for every person's inherent dignity, worth, and unique attributes. Other requisites include nursing responsibilities to patients, patient advocacy, practicing in collaboration with other healthcare professionals, and a commitment to professional growth.

The National Association of Social Workers (NASW) Code of Ethics was updated in 2021, and one of the new provisions added is the importance of professional self-care. Ethical standards include the social worker's ethical obligations to clients, coworkers, practice locations, and the wider community (NASW, 2023).

Other organizations with Codes of Ethics for healthcare professionals include the following:

- American Association of Medical Assistants
- American Chiropractic Association
- American Physical Therapy Association
- American Registry of Radiologic Technologists
- American Society for Clinical Laboratory Science
- Certified Nurse Assistants Code of Ethics
- National Association for Healthcare Professionals (Ritter & Graham, 2017)

Another important resource for healthcare professionals seeking guidance on ethical issues is the ethics committee in their facility. These committees became more widespread in the middle to the late 1980s when questions surrounding life-sustaining medical technology needed to be addressed. The three primary purposes of a hospital ethics committee are to provide education, create policies, and offer consultation on specific issues, such as concerns surrounding end-of-life decision-making (DiNova, 2020).

Definitions

Morality is social conventions about right and wrong agreed upon amongst a population. Morality makes it possible for people to live communally. At times, behaving morally means that the person must forgo their immediate benefits for the well-being of the community as a whole. Other terms associated with morality include:

- Immoral – a description of persons who intentionally do a negative action while knowing the difference between what is right and wrong.
- Nonmoral – this refers to circumstances where morality is not a concern, for example, deciding on what color socks to buy.
- Amoral – descriptive of an individual who recognizes the difference between right and wrong but is not concerned with morality.

It is important to remember that morality is not a fixed concept and can vary among cultures, geographical areas, religions, and even within families. However, some moral beliefs appear to rise above place and time; these are:

- Bravery
- Fairness
- Submitting to authority
- Assisting one's group
- Love of family
- Reciprocating kindnesses
- Respecting the property of others (Morin, 2023)

Life experiences and events can play a role in defining one's moral scope.

Values include your beliefs, likes, dislikes, and preferences. Personal values are educational background, life experience, culture, family, and religious beliefs. Different people have different values. Different cultures have different values, and values are different even within cultures. Values change over time and in different situations. Values form the underlying framework on which we base our actions. They can be described as the baseline of our ethical compass. Values are seen as motivating factors in the individual's life, and generally, those with distinct values consider their lives to be satisfying and meaningful (Weinstein & Wengrzyn, 2022).

Issues can arise when a person holds two conflicting values or beliefs. A person internalizes certain values but acts in a contrary manner; this results in cognitive dissonance, described as a feeling of emotional distress. The term was created by Leon Festinger, a psychologist, in the late 1950s. Although cognitive dissonance is experienced by most people to some extent, from time to time, it is not always easily recognized. Feelings and experiences related to cognitive dissonance include:

- Experiencing unease before carrying out an action or making a decision.
- Attempting to validate or rationalize a decision that one has made or an action done.

- Feelings of guilt and regret and attempting to conceal such actions from others.
- Acting in accordance with social pressure even when it contradicts personal values (Cherry, 2022).

Frequent and prolonged episodes of cognitive dissonance lead to stress. The response of the person to cognitive dissonance includes adopting defense mechanisms such as:

- Avoidance – Keeping away from people or situations that evoke memories of the dissonance. Occupying oneself with chores and responsibilities that provide distraction.
- Disempowering – This includes diminishing the proof of the dissonance.
- Restricting effect – this strategy limits the distress of cognitive dissonance by belittling its significance. The person may dismiss their actions as an unusual or never-to-be-repeated happening or by offering a realistic point-of-view to prove to themselves and others that their action is acceptable.

Conversely, a person may act to resolve the contradictions that lead to cognitive dissonance in the first place. The most effective course of action is to change one's behavior or values and beliefs so that they are in accordance with one's actions (Villines, 2022).

Personal ethics and values differ from professional ethics and values. Your ethics and values affect your practice. Value and ethical conflict occur if you fail to recognize that values and beliefs are different for individuals of different cultures and within the culture.

Ethical Principles Commonly Affecting Healthcare Professionals

Table1: Ethical Principles Commonly Affecting Healthcare Professional

Autonomy	• Self-governance • Right to make an informed decision • Informed consent process • Right to determine the course of treatment
Beneficence	• One ought to do or promote good • Positive benefits are what the healthcare providers are obligated to seek • Act for the good of the individual
Clinical Equipoise	• The uncertainty that treatment will be beneficial (research, off-label use)
Equal Consideration of Interest	• Weigh the interest of all affected individuals equally in calculating the rightness of an action
Fidelity	• Responsibility • Doing one's duty • Keeping one's word • Faithfulness • Maintain confidentiality

Distributive Justice	• Fairness in the allocation of resources • Equal access • Fair share of resources
Duty	• Commitment or expectation to perform some action in general or under certain circumstances
Justice	• Duty of a healthcare professional to tell the truth • Veracity • Truthfulness
Golden Rule	• Treat others as you wish to be treated
Lesser of Two Evils	• Faced with only immoral options, select the least immoral
Nonmaleficence	• Do no harm • Avoid harm
Paternalism	• Healthcare professionals make healthcare decisions for the patient because they know what is more beneficial for the patient • Disregard for patient's autonomy
Respect for Persons	• All people deserve the right to exercise their autonomy
Rule of Rescue	• Duty to save endangered life if possible • Save individual life regardless of cost
Sanctity of Life	• Life is so valuable it is not to be violated • Life is holy, sacred
Truth	• Being in accord with fact or reality
Two Wrongs Do Not Make a Right	• The rebuke of wrongful conduct in response to another's transgression
Utility	• Assigning a perceived value or worth to available options
(Morin, 2023; Villines, 2022; Weinstein & Wengrzyn, 2022)	

Ethical Dilemmas

Some areas where clinicians are faced with ethical dilemmas about healthcare include:

1. Balancing the safety of care with efficiency and limited resources.

- If a patient needs to be on a ventilator, and other factors are consistent, they are placed on a ventilator; this is a simple ethical decision. What if five patients need mechanical ventilation, and only three ventilators are available? Before 2020, most administrative or clinical healthcare professionals would have responded that it would be a difficult ethical decision. Still, fortunately, it was theoretical since most providers had never encountered this in real-life practice. However, the COVID-19 pandemic changed all that. Ethical issues that were once straightforward became complex, with many layers of decision-making to be worked through. Globally, it has become a question of the allocation of scarce resources.
- A primary need during the COVID-19 pandemic – and future pandemics – is to have an ethically comprehensive framework to direct clinical decision-making. One of the issues that had to be addressed during the COVID-19 pandemic was promoting and sustaining population health, using the resources available to enhance the overall number of lives saved. The prudent use of resources at times placed limitations on individual rights. However, a sound ethical framework demands that such limitations must be used in a manner that is consistent, necessary, impartial, and proportionate.
- In circumstances like the COVID-19 pandemic, the standard priorities of healthcare professionals change. The alteration is referred to as the crisis standard of care, acknowledging limitations during periods of scarcity. In the context of the events, the healthcare professional considers what is ethically optimal and possible for each patient. Along with a duty to care for patients just and equitably, this ethical guidance is also founded on the responsibility to safeguard resources and accountability (Sese et al., 2020).

2. Improving access to care.

- The idea that everyone should have the same access to healthcare is, in practical terms, just that – an ideal. In the real world, many obstacles can and do raise ethical issues. For example, patients who require treatment may have to be placed on a waiting list, depending on their geographical location, access to medical resources, and amount of skilled practitioners. An important dynamic to remember is that ethical is not equal to lawful. An action may be unethical but completely lawful. To look at this concept in practical terms as it applies to healthcare, an emergency department could be continuously overcrowded; however, this does not place a legal responsibility on the healthcare providers to increase the pace at which care is delivered. But, it could be judged to be an ethical responsibility on the part of the healthcare providers to raise this problem with the facility administration and explore solutions to this problem (Sermo Team, 2023).
- One of the major barriers to accessing healthcare is insufficient health insurance. Adults lacking healthcare insurance are less likely to get preventive care for chronic health problems like cancer, heart disease, and diabetes. Likewise, children without healthcare insurance risk not getting adequate treatment for disorders such as asthma, preventive dental care, immunizations, and well-child visits that monitor the achievement of developmental milestones. Medicare and Medicaid coverage have significantly improved access to healthcare services. A study showed that when previously uninsured individuals reached Medicare eligibility at age 65, their utilization of essential healthcare services grew.
- Similarly, Medicaid coverage provides vital healthcare services to formerly uninsured adults and children. However, Medicaid recipients can still experience difficulties accessing healthcare and dental care if they reside in an area where few providers

accept Medicaid insurance. The main reason for this is that Medicaid pays reduced rates to providers.

- Providing wider availability of affordable healthcare insurance is essential in reducing inequality in healthcare services. But other issues must also be considered, such as cultural, social, and geographic impediments (Trotochaud, 2006).

3. Addressing end-of-life issues in the context of increasing average life expectancies and aging populations.

- Dealing with end-of-life issues can be difficult for families and healthcare providers. The best scenario is that patients have put in place end-of-life directives well in advance when they can make their wishes known and choose the person, or persons, who they believe will be capable of following through on their directions. Deciding to follow a directive to withhold life-sustaining treatment can be difficult and a highly emotional decision for the person invested with healthcare power of attorney. To handle these situations that may arise, healthcare professionals must stay up to date in their knowledge of the laws and rules surrounding end-of-life care. The knowledge base includes understanding federal, state, and local laws and related professional rules (Ritter & Graham, 2017).
- It is important for all involved to remember that from an ethical standpoint, the patient, rather than family members or healthcare providers, makes end-of-life decisions. When patients cannot make decisions, a family or healthcare proxy will be called upon to decide what care will be provided. Usually, in these circumstances, families lean heavily on healthcare professionals' guidance in decision-making. Healthcare professionals can find themselves in difficult situations when family members disagree, some demanding that "everything" be done to sustain the life of their loved one. In contrast, others are unsure and request healthcare professionals to decide for them. In situations where there is discord between family demands and what the healthcare team considers to be in the best interests of the patient, assistance from the facility's ethics committee can be requested (Akdeniz et al., 2021).

4. End-of-life care for children and minors.

- In the United States and most other countries, the parents or legal guardians make the decisions for end-of-life care for children. These situations can involve some of the most difficult ethical decisions to make. Decisions regarding care are made from the perspective of what is in the child's best interest. Determining best interests entails assessing the advantages, complications, and risks of treatment to attain the most feasible outcome for the child or adolescent.
- It is important to keep in mind that while youths under the age of 18 years are not legally regarded as competent to make their own decisions, there are exceptions to this rule, such as children who live autonomously, away from their families, fiscally independent children, pregnant women, and married women. It is also recognized that children over the age of six should be told about the decisions pertaining to their end-of-life care, and their requests are considered when care decisions are being made (Akdeniz et al., 2021).

5. Access to medications can be costly but life-saving.

- While there have been incredible advances in the discovery of new medications to treat a wide array of conditions, including genetic disorders, cancers, and neurological ailments, prohibitive costs put them out of the reach of many who would benefit most from them. In an attempt to address this problem, a law signed in 2022 places a cap of \$2,000 yearly maximum on out-of-pocket costs for Medicare

patients, but it does not take effect until 2025. However, this may still place many medications beyond the budget of a significant number of persons, and research has found that many patients stop filling prescriptions when confronted with \$2,000 in costs. One of the revealing signs that a particular treatment is effective is the same treatment outcomes being seen between wealthy patients and the rest of the population (Kolata & Paris, 2023).

- The Centers for Medicare and Medicaid Services predict that this country's net spending on prescription drugs will increase more rapidly than any other main healthcare service over the coming decade. One of the concerns presented by high medication costs is that entities outside the established patient and healthcare provider relationship cause them. A healthcare provider may recognize the benefits of a particular drug for a patient while at the same time dealing with the reality that the drug is well beyond what the patient can afford. A recent study by the Kaiser Family Foundation found that over 50% of those with employee-sponsored health insurance stated that they had delayed recommended treatments for themselves or someone in their family due to the cost of care. Another ethical question is raised: are medications priced fairly in the United States compared to other countries? Drug companies defend the high costs by stating that they are necessary to recover the amounts spent on research and developing new medications. A study conducted in 2017 of the top twenty selling medications demonstrated that the variance in price between the United States versus cost outside of the United States allowed the drug companies to recover their research and development expenditures, with \$40 billion available for profit (Tsou et al., 2021).

6. Allocation of limited donor organs.

- When it comes to donor organs, there is a considerable disparity between the number of available organs and those who require transplants. The shortage results in the ethical dilemma of prioritizing donor organ recipients. In many instances, this is a life-and-death decision. Without a new organ, a patient may die. Factors taken into consideration in organ donor allocation include medical importance, the length of time the patient has been on a waiting list, age (such as under 18 years of age), and the likelihood of transplant success (Oedingen et al., 2020).
- Around 90,000 individuals are awaiting a kidney transplant. The equitable distribution of donor organs is critical in this situation. The organ donation and transplant community is moving towards a more impartial organ allocation system to achieve this. It is referred to as continuous distribution and is based on the premise that no single factor will determine priority for organ allocation. Multiple elements will be measured simultaneously, resulting in a more impartial and accommodating system (United Network for Organ Sharing [UNOS], n.d.).

7. Patient confidentiality.

- Confidentiality is at the core of the patient and healthcare professional relationship. A patient's right is to anticipate their personal information being held in confidence by clinicians providing their care. Confidentiality permits the patient to fully reveal information about their health and well-being without worrying that others will become aware of the information disclosed. The open flow of communication allows for an accurate diagnosis and implementation of treatments. Clinicians who share information about a patient with a third party without the patient's consent have violated the confidentiality rule, even if the disclosure is accidental (Ritter & Graham, 2017). How a breach of confidentiality happens is not a consideration. It can

happen in any manner that information is conveyed, such as oral, face-to-face, written, electronic, fax, or telephone.

- However, there are some instances where disclosing confidential patient healthcare information is permissible without being seen as an ethical violation. Whenever feasible, patients should be told about such disclosures. However, their consent is not needed. These instances can include a court order, which permits investigators in the alleged criminal activity of a healthcare provider to examine the provider's records. Another instance is mandatory reporting. Healthcare professionals are legally responsible for reporting certain conditions to the appropriate authorities. Examples of these situations include suspected child abuse, sexual abuse, elder abuse, and gunshot wounds. In these circumstances, sharing information is deemed to be in the best interest of society and supersedes the right of patient confidentiality.
- Communication of specific communicable diseases is another mandatory requirement where the welfare of society is put before individual confidentiality rights. County health departments and the Centers for Disease Control and Prevention track the rates of certain diseases, and this process necessitates access to patient's healthcare information. Other circumstances where ethical and legal causes can require the disclosure of patient information include situations where there are threats of self-harm or threats to endanger the safety of others.
- The laws and ethical considerations of confidentiality for minors differ from those of adults. In most situations, healthcare providers must include parents or legal guardians in the decision-making and treatment of children. However, children can make some healthcare decisions without the consent of parents or legal guardians. In these instances, minors are allowed the same standards of confidentiality as adults. The decisions in question and the age at which the minor is entitled to make them independently differ from state to state. For example, minors 12 years and older in Illinois can obtain treatment for sexually transmitted diseases, drug use, alcohol consumption, and outpatient mental health services without parental or guardian consent (Nolan, 2021).
- It is important that all healthcare professionals are aware of their state's laws regarding consent for minors and instances in which treatments do not require parental permission. Also, it is imperative for healthcare professionals to take added precautions to protect minor confidentiality in electronic records and healthcare insurance billing in these exempt situations (Davis & Fang, 2023).



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8. Disclosure of medical errors.

- A 2016 report from Johns Hopkins University estimated that over 250,000 people in the country die annually due to medication errors (Ritter & Graham, 2017). Once a healthcare professional finds or suspects that they have made a medical error, they are responsible for reporting it. However, several ethical issues are involved in reporting medical errors, as highlighted in RaDonda Vaught's case.
- Ms. Vaught, an RN at the time, reported a serious medication error that caused the death of a patient. Criminal charges were brought against Ms. Vaught, which led to a national outcry among nurses that she was being scapegoated to cover up deficiencies in the facility where she worked. Nursing organizations judged it to be a "dangerous precedent" to turn a medical error into a criminal prosecution and that it would result in healthcare professionals being less willing to report errors in the future.
- Another ethical problem the Vaught case highlighted was a lack of standard error-management reporting systems in many healthcare facilities. RaDonda Vaught reported the fatal error to her supervisors once she learned about it. Still, the hospital administration failed to report the incident to the local, state, and federal authorities. The lack of support from her employers for nurse Vaught caused a widespread feeling among nurses that it was "everyone for themselves" (Vemuri et al., 2022).
- On March 25, 2022, a jury found Ms. Vaught guilty of criminally negligent homicide and felony abuse of an impaired adult (Harrington, 2023). The president of the Institute for Safe Medication Practices (ISMP) responded to her conviction by stating that "the entire healthcare community lost . . . her conviction made a scapegoat of one individual instead of focusing on fixing larger, preventable systemic issues." He predicted that Ms. Vaught's criminal trial and conviction "would have serious consequences for patient safety," with less reporting of medical errors resulting in an inability to learn from them and prevent future occurrences (ISMP, 2022).
- The DaRonda Vaught case and conviction raised many ethical issues. Vaught took responsibility for her actions, including overriding the facility's computer system, resulting in her gaining access to the wrong medication. She failed to note the warning label on the medication vial or that the composition of the medication she retrieved differed from the medication she intended to use.

- In 2016, the year before this fatal incident, the ISMP issued a medication safety alert about using neuromuscular blockers after several near misses or potentially fatal accidents that were caught in time had been reported. The ISMP made several primary recommendations, which, according to the ISMP, "should be given the highest priority by hospitals and surgery centers" (ISMP, 2022). Among the primary recommendations was to limit access. The unit stock of neuromuscular agents would only be permitted in areas of the facility where patients could be appropriately ventilated. Several facilities implemented the ISMP recommendations, while others did not.
 - Tennessee investigators found that Vanderbilt Hospital, where the incident occurred, bore a heavy burden of responsibility; however, no charges were filed against them. The changes being made to their electronic system when this fatal error occurred resulted in recurrent difficulties with medication dispensing.
 - Another important ethical consideration in such tragedies is the rights of patients and families to full and complete disclosure of what happened. In the Vaught case, the deceased's family was initially told that the patient had died from natural causes. When the family finally became aware of the circumstances surrounding the death, Vanderbilt agreed to a settlement. Part of the settlement included a stipulation that the family would never openly talk about the medical error or death. The case came to light through an anonymous tip to the Centers for Medicare and Medicaid Services, who started an investigation (Callahan, 2022).
9. Religious or cultural beliefs differ between patients and healthcare professionals.
- Differences in cultural backgrounds and religious beliefs can cause ethical dilemmas between patients and healthcare professionals. Healthcare systems are charged with the delivery of culturally competent care. Cultural competence is defined as the capacity to provide healthcare services that speak to the cultural, social, and religious needs of patients and their significant others. Culturally competent care has been shown to improve patient outcomes. However, a question arises: is culturally competent care compromised when ethical differences surface between patients and healthcare providers? Take, for example, the issue of abortion. Listed below are the major beliefs of some religions on this issue:
 - The Bahá'í faith – does not believe in abortion.
 - Buddhism – Abortion is allowed in certain limited circumstances.
 - Church of Jesus Christ of Latter-Day Saints (Mormons) – abortion is allowed in the case of rape or when the mother's life is in danger.
 - Hinduism – Abortion is permitted if the mother's life is in danger.
 - Islam – Abortion is only allowed in instances of rape, incest, or when the mother's life is threatened.
 - Judaism – Abortion is permitted to save the life of the mother.
 - Catholic Church – abortion is not allowed (Swihart et al., 2022; Whitaker, 2022).

These are a handful of examples, and it is important to remember that within the various strands of world religions, such as Judaism, Christianity, Islam, Buddhism, and Hinduism, there are differing beliefs on abortion. A survey conducted by the Pew Research Center in March 2022 found that the majority of Americans do not hold stringent opinions on abortion – requiring that it either be totally banned or allowed without restrictions. Data from the survey showed that close to 75% of adults believed abortion should be allowed if the pregnancy puts the woman's life or health at risk. However, the survey also showed that a significant portion of the population believed that some restrictions should be placed on abortions; for example, seven in

ten adults favored a requirement that made it obligatory for healthcare professionals to inform the parent or guardian of minors requesting abortions. The survey also found that disapproval of abortion rises at later stages of pregnancy; at 24 weeks gestation, almost twice as many people state that abortion should be illegal versus those who support its legality.

When it came to the question of penalties for those who performed abortions in circumstances where it is against the law, the following data was compiled from the survey:

- The majority opinion is that healthcare professionals who perform abortions in circumstances where they are illegal should incur penalties.
- 25% state that healthcare providers who perform abortions illegally should receive jail time.
- 31% believe that healthcare providers who perform abortions illegally should have their medical licenses revoked.

Regarding attitudes to those who have an illegal abortion, the survey demonstrated that the population was divided almost evenly, with close to 47% stating that those who have an illegal abortion should be punished. In comparison, at least 50% believe they should not be punished (Pew Research Center, 2022).

Concerning the belief that abortion should be legally allowed if the woman's life is in danger, the question remains how imminent the risk to a woman's life must be. Healthcare professionals have pointed out that many women have stable, pre-existing conditions when pregnant. Still, as the pregnancy progresses, these conditions can become life-threatening, which posits the question of provisions for abortion in life-threatening conditions applying to later stages of pregnancy (Simmons-Duffin, 2022). Also, is it ethically feasible to restrict life-saving care based on the stage of pregnancy?

Many ethical dilemmas may have medico-legal implications. It is crucial that healthcare professionals:

- Use evidence-based practice
- Be aware of their legal duties to a patient
- Provide a reasonable standard of care that would hold up to professional review should there be any accusations of medical negligence
- Document thoroughly and timely

Theories of Ethical Decision-Making

Ethical dilemmas usually involve making difficult decisions. Decision-making often requires recommendations by the clinician, information about the patient's best interest, or choosing suitable treatments and interventions. Criteria frequently used to determine the best interest of the patient include the following (Varkey, 2021):

- Determining what the patient finds acceptable or unacceptable regarding the quality of life
- Reviewing the benefits and risks of each reasonable intervention
- Characterizing the risk and the degree of suffering and pain associated with an intervention
- Giving the expected prognosis with and without treatment

Healthcare professionals who limit ethical decision-making to one framework may cause conflict with the patient and their loved ones. Multiple ethical frameworks should be considered, particularly in complex clinical situations.

The most common framework for medical ethical reasoning in the United States is principlism. It encapsulates four comprehensive and basic ethical principles:

- Respect for Autonomy
- Beneficence
- Nonmaleficence
- Justice (Beauchamp & Childress, 2013)

Principlism decision-making becomes stuck when principles or their specifications contradict each other (Beauchamp & Childress, 2013). For example, a patient with end-stage cancer may have the personal belief that they must be told so that they can make decisions and use their remaining time well. However, the patient's family may insist that the patient not be told because they believe that knowledge will rob them of the will to live. In such a situation, the principles of respect for autonomy and nonmaleficence are at odds. So, who decides what happens to the patient?

Several frameworks exist to aid healthcare professionals in dealing with ethical questions that surface during clinical care. The framework introduced by Jonsen (2006), described as the "Four Box Model" for clinical ethical decision-making, helps clinicians prioritize the ethical principles of the clinical situation. The model balances medical decision-making elements that are important to health professionals with those patient-centered elements important to patients (Toh et al., 2018).

Table 2: Four Box Model

Clinical Indications	Patient Preferences
Beneficence and Nonmaleficence • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient benefit from medical and nursing care, and how can harm be avoided?	Respect for Autonomy • Is the patient mentally capable and legally competent? Is there evidence of incapacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision-making? • Has the patient expressed prior preferences, e.g., advanced directives? • Is the patient unwilling or unable to cooperate with medical treatment? If so, why? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
Quality of Life	Contextual Features

Beneficence, Nonmaleficence, and Respect for Autonomy

- What are the prospects, with or without treatment, for a return to normal life?
- What physical, mental, and social deficits will the child likely experience if treatment succeeds?
- Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
- Is the patient's present or future condition such that their continued life might be judged undesirable?
- Is there any plan and rationale to forego treatment?
- Are there plans for comfort and palliative care?

Loyalty and Fairness

- Are there family issues that might influence treatment decisions?
- Are there provider (physicians and nurses) issues that might influence treatment decisions?
- Are there financial and economic factors?
- Are there religious or cultural factors?
- Are there limits on confidentiality?
- Are there problems with the allocation of resources?
- How does the law affect treatment decisions?
- Is there any conflict of interest on the part of the providers or the institution?

(Toh et al., 2018)

Utilitarians/consequentialists view stress as maximizing the balance of benefits and burdens, the greatest good for the greatest number. Consequentialism decides whether an action is right based on its consequences. For example, a utilitarian approach to deciding whether or not to offer cardiopulmonary resuscitation to a patient would weigh the likelihood of survival and subsequent quality and quantity of life against potential suffering and costs. A criticism that is sometimes leveled at consequentialism is that it can be challenging or even impossible to identify the result of an action in advance (McCombs School of Business, 2020).

The deontological view focuses on professional duties and a clear set of rules or principles. The word deontological is derived from the Greek word "deon," which denotes "duty" or "obligation" (Barrow & Khandhar, 2022). For example, palliative care involves clinicians arguing for withholding or withdrawing treatment based on a utilitarian assessment of futility. Still, the family members argue for continued treatment out of familial duty.

The communitarian view emphasizes the importance of community, the common good, social goals, traditional practices, and cooperative virtues. It places stress on the effect that community has on the lives of human beings (Philosophy and Education, 2006). For example, communitarians argue in favor of universal access to health care because it improves the quality of life for the entire community.

The principle of double effect (PDE) goes back to medieval times and Thomas Aquinas. Today, it is used to appraise actions with multiple consequences, some of which are regarded as corrected from a moral standpoint. In contrast, others are regarded as erroneous or immoral (McCombs School of Business, 2013). Principles include the following:

- The action taken is morally good or neutral. A good outcome is intended from the action while recognizing the possibility of a negative outcome.
- The intended outcome is important enough to justify the unlikely but possible bad effect.
- Efforts are undertaken to minimize the risk of the bad effect.

- The unintended effect is not the means to achieve the desired effect.

PDE is often used in the decision to give enough pain medicine at the end of life to relieve pain, even though it may suppress respiration. There is generally an ethical consensus about the standard treatment of pain at the end of life. The position of the World Health Organization and the United States Supreme Court is that effective treatment of pain at the end of life is legally and morally acceptable. It is seen as a fundamental right of the patient (Jackson & Leiter, 2023). Even if the medication hastens death, the action intends to relieve pain and not cause death.

Rights-based approaches emphasize the rights of individuals; for example, patients near the end of their lives have the right to participate and benefit from appropriate research. A necessary feature of rights-based approaches is treating people as ends, not merely as a means to an end. It ensures that people are told the truth, have a right to privacy, and are not harmed, exploited, or subjected to injustice or discrimination (Master Class, 2022).

Ethics of caring (or feminist ethics) holds that natural caring for others is the basis for moral behavior. It stresses caring relationships with others not based on individual rights but on a strong sense of responsibility, for example, by explicitly taking the patient and their family as the unit of care, not just the patient. Another example of the ethics of caring is military nurses in war zones providing responsive, competent care to patients regardless of their backgrounds or affiliations (Hepler, 2022).

Virtue ethics focuses on the moral character which informs behavior. The character-based approach presupposes that individuals develop virtue through practice. According to the Greek philosopher Aristotle, practicing virtuous behaviors makes a person more apt to make the right choice when confronted with ethical challenges (McCombs School of Business, 2013). The virtues emphasized in hospice and palliative care practice include compassion/empathy, faithfulness, justice/advocacy, and practical wisdom.

Ethical relativism holds that morality is relative to the norms of one's culture. There are no absolute truths, no moral right or wrong. The approach maintains that the morals of society evolve and shift over a period of time depending on social standards (All About Philosophy, 2021). What is morally right or wrong varies from person to person or from society to society. Variances in culture and society influence whether an act is moral.

Whatever approach is taken, utilizing the different perspectives and skills of the interdisciplinary team members to address ethical issues is needed.

Decision-Making Capacity

Patients' right to make healthcare decisions is fundamental to the ethical principle of respect for autonomy and is a key component of informed consent to medical treatment. Informed consent does not comprise a guarantee of flawless information or assured results. Still, it indicates confidence in the information provided and those providing it. Effective listening is essential to informed consent, whether you are the giver of information or the receiver. It involves focusing attention on what is being said and how it is being said so that its full meaning is captured. Attention must be paid to specifics and nuances, including the significance of what is not actually said; otherwise, there is a danger of missing the nature and extent of possible deficiencies in the information (Liataud & Sweetingham, 2021).

Ineffective listening is problematic and raises ethical issues, especially when important decisions need to be made. Patients may hear what they expect or want to hear rather than the information being conveyed to them; this is defined as the echo chamber, where we listen to

ourselves rather than the person speaking to us. Another mistake that can be made is to predict or assume what the other person is thinking or feeling (Liautaud & Sweetingham, 2021).

A healthcare professional may have a preconceived idea about how a patient may or should react to information; this can be based on the professional's experience and how patients in similar situations react. However, this fails to consider the individuality of each patient and the need for the healthcare professional to gear their responses toward the concerns of the patient they are dealing with. If the patient's reaction is unexpected and seems unusual for the circumstances, the provider needs to ask themselves what they are missing and, why they are missing it, and if they are asking the right questions. Caution must be taken about asking binary questions requiring a simple yes or no answer. These types of answers provide little or no understanding of what the patient is thinking or feeling. Healthcare professionals must also be careful not to attribute their biases and misinterpretations to what a patient is saying (Liautaud & Sweetingham, 2021).

Determining whether an individual has adequate capacity to make decisions is an inherent aspect of all patient interactions. The main determinant of capacity is cognition. The patient's condition or treatment that may affect cognition potentially impairs decision-making capacity. Determining whether a patient has adequate capacity is critical to respecting patient autonomy while acting in a patient's best interest. A technique used at the Stanford Center for Biomedical Ethics is to ask the patient to discuss a topic separate from the medical intervention to measure their perception of the framework of their decision. For example, the healthcare provider may discuss the patient's day or an event in the news, topics unrelated to consent, to confirm subtleties in the person's mental state (Liautaud & Sweetingham, 2021). Capacity assessment can determine the severity of a patient's cognitive impairments and improve the effectiveness of conversations with patients and their families.

Capacity and competency are often used interchangeably, but there are differences. Capacity describes a person's ability to decide within a given situation. When evaluating capacity, factors that need to be considered include the patient's age, severity of the illness, and overall functional status. It is also important to remember that evaluating a patient's capacity can only be accurate within the circumstances, time, location, and state where the assessment took place. Changes in a patient's condition or external factors can adversely impact a patient's decision-making capacity (Libby et al., 2023). There is no definitive test of decision-making capacity. The Mini-Mental State Examination, or similar ratable instruments of cognitive function, do not determine the ability to make medical decisions apart from in cases of severe loss (Silveira, 2022).

Competence refers to a legal judgment on whether individuals have the legal right to make their own decisions. It determines a person's ability to participate in legal procedures. Legal competency is assumed – and refuting a person's competency necessitates a hearing and presentation of evidence to substantiate the claim. Legal competency is established by a judge, not a healthcare professional (Libby et al., 2023).

Patient coercion in decision-making is another consideration that healthcare professionals must be aware of. Informal coercion is, at times, used in adult psychiatric inpatient facilities and has been portrayed as a necessary evil (Andersson et al., 2020). Regarding informed consent, the concept of voluntariness demands that the patient's consent to treatment is free from coercion, compulsion, or unwarranted influence (Somerville, 2021).

Advanced Care Planning

Advanced care planning (ACP) helps avoid ethical dilemmas. It supports patients at any age or stage of health in understanding and sharing their values, life goals, and preferences regarding future medical care. It ensures that a person receives medical treatments that align with their values, objectives, and preferences. Ideally, ACP should be a proactive process incorporated into routine healthcare. It is advisable to revisit ACP whenever there is a change in the individual's health condition; this allows the person to modify any aspects of the ACP that they feel no longer meet their needs (Silveira, 2022).

ACP not only guarantees that healthcare professionals engage in discussions with patients and their significant others about their requirements for future health care, but it also ensures that the content of those interactions is documented in a manner that moves with the patient as they transfer across various healthcare settings (Silveira, 2022).

ACP can involve the completion of advance directives (AD), a document where the patient states their preferences for medical care and assigns a proxy decision-maker. There are numerous types of ADs; however, the types normally accepted by state law in this country are the living will (LW) and the durable power of attorney for health care (DPAHC). LWs record an individual's choices for life-sustaining interventions and resuscitation. DPAHC, also known as health care proxy designations, records the selection of a proxy decision-maker (Silveira, 2022).

A significant drawback of an LW is that it may not be germane to every patient's occurrence; this underlines the importance of having a proxy decision-maker in place, as they can give direction to healthcare providers in instances where the patient is incapacitated and the content of the LW is not applicable (Silveira, 2022).

Social workers or nurses often do ACP as a part of case management or discharge planning. The best scenario is to have a clinician who collaborates with the healthcare providers to engage with the patient. The clinician should be qualified to provide the patient and significant others with information about the patient's prognosis and describe the treatment options available along with their benefits and risks. Clinicians must be sensitive that this process is usually not completed with one encounter with the patient and significant others or input from a single provider. It is a process that can require several visits with the patient and family and the involvement of multiple healthcare professionals who direct the patient's care (Silveira 2022).

Studies show that ACP increases the patient's and family's quality of life. Data indicate improved outcomes in several domains, including:

- Greater frequency of completion of ADs
- Decreased use of cardiopulmonary resuscitation
- Decreased in life-sustaining treatments
- Increases use of hospice and palliative care services
- Reduces the rate of subsequent hospitalizations
- Better communication between patients, significant others, and healthcare professionals
- The greater probability that the person will die in their preferred location
- Findings of decreased stress, anxiety, and depression among families and significant others of deceased patients (Silveira, 2022)

However, notwithstanding ACP's established benefits, few individuals engage in the process. In this country, the capacity to bill for ACP services through Medicare improved the frequencies of ACP; however, the rate remains below 7.5% (Silveira, 2022).

Case Studies

Scenario 1:

Sue works the evening shift at a nursing home at 3:30 p.m. Sue receives a call from her child's care provider, and her child is sick. She asked the charge healthcare professionals if she could check on her child; this conflicts with Sue's value of her child's health and her professional, ethical responsibility of fidelity in doing one's duty. If the charge healthcare professional allows Sue to go home, this resolves her conflict. If the charge healthcare professional does not allow Sue to go home, the conflict remains unresolved.

Scenario 2:

Mr. X's physician has asked home health care to evaluate him for home health services. It is determined that Mr. X requires patient education related to his diet and medication. Physical therapy is also ordered. Mr. X allows the healthcare professional to come but refuses physical therapy. After Mr. X refused to open the door for the therapist, the healthcare professional and therapists arranged to come together. Mr. X continues to refuse to participate in the physical therapy regimen; this is an ethical conflict between fidelity and beneficence in doing one's duty to carry out a beneficial patient care order and the patient's autonomy in his right to choose.

Scenario 3:

Ed recently received a concussion while participating in football practice one week prior to the season's final football game, which also happened to be a state playoff game. The concussion was his third concussion within a year. The athletic trainer and team physician spoke to Ed and his father about the need to refrain from contact sports until being evaluated and cleared by a neurologist. Ed's father, who also happens to be one of the coaches for the football team, felt the team needed him to win the game and did not want Ed to miss his last ever football game. Ed felt he would be letting down his team if he missed such an important game; he wanted to participate; this is a conflict between nonmaleficence in avoiding further harm and autonomy in the patient's right to choose.

Scenario 4:

A 62-year-old diagnosed with squamous cell carcinoma with metastasis to the brain, Gary, underwent a craniotomy to remove a large mass in his brain. Post-surgery, Gary must undergo short-term intensive rehab followed by radiation and chemotherapy. Gary's prognosis is fair due to the aggressiveness of his cancer. Gary is admitted to the inpatient rehabilitation facility with an estimated length of 21 days to be discharged to his home, where he lives with his wife, who has multiple sclerosis. Gary progresses nicely in occupational and physical therapy. Achieving most goals, and since family training is completed, Gary will be discharged the upcoming morning. On the morning of discharge, Gary's wife indicated she could not provide the occasional skills needed for mobility and activities of daily living. She wants Gary to stay at the facility or go to a skilled nursing facility (SNF) for more therapy. Gary's insurance will not allow Gary to remain in the facility for continued therapy. Gary desires discharge home, stating, "I need to get started with my cancer treatments," which cannot be provided in an SNF setting. The healthcare team discharged Gary to the SNF. The team has utilized paternalism, believing it is more beneficial for Gary to go to an SNF vs. autonomy and Gary's preference to be discharged home.

Mandatory Treatments

The issues surrounding mandatory treatments have become a topic for debate considering COVID-19 vaccine mandates for healthcare workers. The message to healthcare professionals in

some settings and facilities was clear: comply with mandatory vaccination or face possible termination. Many healthcare professionals followed the vaccination mandate regarding it as part of their responsibility to protect society. Ethically, it was a decision to put the welfare of others above their self-interests. In this context, many healthcare workers who were dubious about the efficiency of the vaccine still decided to get it (Myers et al., 2023).

However, the validity and effectiveness of mandatory COVID-19 vaccines have been questioned. Some saw mandatory vaccine policies to be scientifically problematic. Arguments supporting this position included diminishing efficacy against infection and transmission at 12–16 weeks post-vaccination. Data also supported that once infected, vaccinated and unvaccinated persons transmitted the virus to others at comparable rates. It was also posited that a blanket mandate policy did not consider the significant risk variance across populations. The underlying concern was that vaccine mandates would infringe on human rights, erode public trust in the healthcare system, and negatively impact vaccine confidence (Bardosh et al., 2022).

Another area where ethical questions arise is compulsory treatments for mental health disorders. Compulsory outpatient treatment in mental health (COT), also called community treatment order, poses substantial ethical questions. It occurs globally in more than 75 jurisdictions; however, the evidence regarding COT's effectiveness is unclear (Martinho et al., 2022).

In the United States, many cities have created new policies to combat homelessness, serious mental illnesses, and substance use disorders. A proposal central to most of these policies is involuntary treatment. In November 2022, the mayor of New York City announced a proposal to employ mental health regulations to enable involuntary treatment when individuals are incapable of caring for themselves or when their behaviors pose a danger to others. Similar proposals have been approved in California and Oregon. Court-mandated treatments can incorporate therapeutic interventions, medication management either in a facility or on an outpatient basis, assistance from social workers, and housing referrals (Drabaik, 2023).

In Portland, Oregon, the base cause of homelessness is the high cost of accommodation and financial difficulties. Only one in three persons who are homeless in Portland state that they have a psychiatric illness, substance use disorder, or both. However, combining one or both of these disorders and homelessness has resulted in numerous public tragedies. Examples of these include persons with schizophrenia freezing to death on city streets. Homeless persons have given birth to premature infants that do not survive the ordeal. Research findings show that homeless people in Portland die thirty years earlier than the average adult in this country.

Civil commitment is not a new concept; it has existed for decades. However, it has recently gained attention as a means of tackling the juncture of homelessness, psychiatric illness, and substance use disorder. Two theories are invoked as the foundation for laws that permit civil commitment. The first is the principle of 'parens patriarch,' a Latin expression that translates as 'parent of the nation'; this principle asserts that states have a legal and ethical duty to step forward and assist vulnerable persons who cannot care for themselves. The second legal premise used is that states have an obligation to enact and apply laws to maintain public health and safety, which can be adversely impacted by homelessness (Drabaik, 2023)

States differ in the content of their civil commitment laws. Since these laws provide a civil process for courts to supervise treating persons with serious mental illness or substance use disorders, they do not criminalize homelessness or employ punitive measures. While 'homelessness' is an all-inclusive descriptor, this population includes several sub-groups with varying needs. However, the most noticed group is the chronically homeless lacking shelter, with the highest incidence of untreated mental illness and serious substance use disorders. A

study conducted in California that looked at 64,000 persons within fifteen states who were homeless discovered that 78% of unsheltered homeless persons had a mental illness, and 75% suffered from a substance use disorder. 50% of those surveyed had both diagnoses. Healthcare providers know that psychiatric illness and substance use disorders play a role in homelessness and worsen the problem. The impetus for changing the civil commitment law in Oregon is to give physicians more flexibility in requiring treatment for patients who are too ill to recognize their need for care. The case put forward is that persons left without treatment for psychiatric illness and substance use disorders are caught in an endless cycle between life on the streets, county jails, and state mental hospitals (Drabaik, 2023).

50% of the United States homeless population is reported to live in California. While only around one-third to a quarter of this population suffers from severe psychiatric illnesses, they are the homeless people that residents in California's major cities are most likely to confront. The mayors of these cities, for example, San Francisco, San Jose, and San Diego have voiced their exasperation that the ceiling set for mental health intervention is too high. With mayoral support, lawmakers in California have introduced new laws that would assist in bringing more people into treatment, even if it contradicts their preferences.

While the objectives of civil commitment are to improve the health and safety of people and communities, it does introduce difficult ethical questions, especially around the issue of autonomy– the core belief that people have the right to make decisions for themselves. There is also the question of beneficence, which guarantees that interventions put in place are more beneficial than harmful. Some in authority oppose civil commitment laws and advocate that states should instead depend on voluntary services. They argue that voluntary treatment is equally effective as civil commitment while at the same time preserving the individual's autonomy and freedom to choose or reject treatment. Another argument is that civil commitment infringes on the principle of beneficence since it can stigmatize homeless persons with serious psychiatric illnesses and substance use disorders by suggesting they do not belong in society. There are still others who consider civil commitment as being cruel and intimidating (Drabaik, 2023).

Opponents of civil commitment in California object to the courts having the right to deprive people of their freedom and privacy. They advocate that the state should invest in improved voluntary psychiatric health services. Some of their major concerns center around race. African Americans form disproportionately high numbers of the homeless population and have been historically over-diagnosed with Schizophrenia (Kennedy, 2022). According to many against civil commitment, these more stringent processes will excessively pursue this group.

Those who support civil commitment believe that it successfully connects people with the help they need and satisfies a moral requirement that stops people from experiencing illness and hardship on the streets. Most healthcare professionals assume that individuals can make their own medical decisions in accordance with their values and requirements. But it must be kept in mind that those with serious psychiatric illness or substance use disorder can suffer from diminished ability to consider what is in their best interests and make effective decisions. In actuality, the person's state negates their autonomy. In these situations, it can be argued that involuntary commitment is a positive intervention that enables people to redeem their autonomy. Regardless of how they got there, they are now in an environment that stabilizes their condition and puts them on the road to recovery (Drabaik, 2023). However, there are limitations to this approach; for example, in California and Oregon, current laws do not include substance use disorders as justification for commitment.

Another factor that poses challenges is the inadequate capacity to provide needed treatments. In Oregon, there are long waiting lists with reports that the statewide capacity to provide services for prevention, treatment, and recovery is around 50% of what is required. Overall, in this country, there is a shortage of trained professionals who can provide mental health care; this includes psychiatrists, psychologists, social workers, and mental health and substance use disorder therapists. Data reveals that more than 50% of counties in the United States have no psychiatrists. One of the essential remedies for this problem is to create more residency openings. A positive finding is that more people are attracted to careers in mental health services. In 2022, there were almost twice as many applicants for psychiatric residency as available places (Weiner, 2022).

Moral Distress and Ethical Decision-Making

Moral distress can have serious consequences for healthcare providers on an individual level, the facilities they work in, and the communities they serve. A study conducted between May 2021 and August 2021 in a large urban facility exposed important findings related to moral distress and ethical decision-making. Several tools are used to measure moral distress; the most current is the Measure of Moral Distress for Healthcare Professionals (MMD-HP). The tool has been used by doctors, nurses, and other health professionals. The main mechanisms of the MMD-HP exam are three stages of root causes, which are patient, unit, and system, and comprises 27 different clinical settings with the choice to propose other clinical settings or events that pose a high risk for moral distress. Research in healthcare environments has shown that a more positive ethical environment and the higher degrees of interprofessional collaboration, the lower the level of moral distress (Silverman et al., 2022).

In the study cited above, there were 206 participants. Of these, about 73% were nurses, and a little over a quarter, 27% were physicians. The participants worked in several departments, including medical/surgical, intensive care, and neonatal/pediatric units. Nurses included management, clinical staff, and nurse practitioners. Physicians included attending, consultants, fellows, and residents (Silverman et al., 2022).

Around 25% of those surveyed considered their ethical environment as being average or poor. Only a little over 19% assessed their ethical environment as being good. Findings from the study indicate that nurses had greater intention to leave their profession than physicians, and nurses recognized their ethical situation as being more negative than physicians. Nurses who worked in medical and intensive care units expressed a higher rate of intention to leave compared to nurses who worked in neonatal and pediatric intensive care units. A greater percentage of nurses working in the surgical intensive care units ranked their ethical environment as poor compared with staff working in other units. Some of the issues that nurses cited as leading to moral distress included a lack of a voice and poor team communication (Silverman et al., 2022).

Summary

Healthcare professionals are in a position that requires personal beliefs and experiences to be put aside and place the patient's interest as the highest priority. Healthcare professionals face situations daily where they must make ethical decisions. By employing different theories of ethical reasoning, such as principlism, healthcare professionals are better equipped to make the most ethical choice when facing complex clinical situations. Research in healthcare environments has shown that the more constructive the ethical atmosphere is, the more significant the degree of interprofessional collaboration, resulting in diminished levels of moral distress. Current evidence suggests that the quality of the ethical atmosphere and levels of

moral distress are significant factors related to an individual leaving their position (Silverman et al., 2022).

Implicit Bias Statement

CEUFast, Inc. is committed to furthering diversity, equity, and inclusion (DEI). While reflecting on this course content, CEUFast, Inc. would like you to consider your individual perspective and question your own biases. Remember, implicit bias is a form of bias that impacts our practice as healthcare professionals. Implicit bias occurs when we have automatic prejudices, judgments, and/or a general attitude towards a person or a group of people based on associated stereotypes we have formed over time. These automatic thoughts occur without our conscious knowledge and without our intentional desire to discriminate. The concern with implicit bias is that this can impact our actions and decisions with our workplace leadership, colleagues, and even our patients. While it is our universal goal to treat everyone equally, our implicit biases can influence our interactions, assessments, communication, prioritization, and decision-making concerning patients, which can ultimately adversely impact health outcomes. It is important to keep this in mind in order to intentionally work to self-identify our own risk areas where our implicit biases might influence our behaviors. Together, we can cease perpetuating stereotypes and remind each other to remain mindful to help avoid reacting according to biases that are contrary to our conscious beliefs and values.

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