Teaching Critical Life Issues in Nursing: A Philosophical Analysis

Evelyn G. Hartigan
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TEACHING CRITICAL LIFE ISSUES IN NURSING:
A PHILOSOPHICAL ANALYSIS

by
Evelyn G. Hartigan

A Dissertation Submitted to the Faculty of the School of Education of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

June
1977
Those entering the nursing profession must acquire knowledge and skills in the humanistic as well as the technical sciences. Their goals are to preserve health, to prevent disease, and to care for the ill and dying. In these pursuits they are called upon to counsel, guide, and instruct their clients in situations involving critical life issues. A critical life issue is defined as a human problem with the following characteristics: it causes disequilibrium in the individual's internal or external environment; it requires a solution that is in conflict with the individual's own values and beliefs or is at odds with solutions acceptable by the majority of the population; and it requires a solution within a prescribed period of time. Two examples of critical life issues are analyzed: abortion and euthanasia.

These life issues have reached today a new critical level. It is not that the patient or health professionals are faced with new problems (for abortion and euthanasia are age-old). But scientific and technological advances in the last few decades have presented ethical dilemmas to nurses and to physicians by making possible new and often radical solutions. In addition, the practice of nursing has changed; there is a growing consciousness of the nurse's responsibility; and there is a tradition of non-teaching, non-preparation. In spite of this tradition, nurses are called upon to counsel and instruct their patients in situations involving ordinary and extraordinary life issues. Nurses therefore must adapt to technological changes and must address themselves to the medical-moral problems these technological changes engender.

The purpose of this study is to philosophically analyze the ethical considerations that the rights and obligations of instruction impose on the teaching and counseling of critical life issues to nurses. Within this limiting context, the purposes are to study: (1) the
relationship between the nurse and her patients and the rights and obligations which arise from this relationship; (2) the relationship between nurse-faculty and nursing students and the rights and obligations which arise from this relationship; and (3) the rights and obligations of instruction of the nurse-teacher as a teacher and as a clinical teacher in a professional health setting.

Chapter one defines critical life issues. In preparation for a fuller discussion of life issues, nursing and the scope of nursing practice are also described. A brief history of nursing provides the background needed to understand the relationship of the nurse to life issues. Chapters two and three define abortion and euthanasia and analyze the legal, religious, and sociological implications of these two critical life issues. Chapters four and five discuss the rights and responsibilities of the nurse, the patient, and the nurse-teacher. In order to determine the rights and responsibilities of nurses and patients, the various professional codes of ethics and other statements are used as standards from which these rights and responsibilities can be inferred. It is concluded that the rights of the nurse-teacher ought to be isolated and identified and, further, that there ought to be a code of ethics which is specific for the nurse-teacher. Two statements are made: (1) "A Proposed Code of Ethics for the Nurse-Teacher;" and (2) "A Proposed Nurse-Teacher Bill of Rights." Chapter six offers five recommendations for the graduate preparation of nurse-teachers. This chapter also analyzes the ethical considerations of teaching critical life issues from three related perspectives: the teacher, the program, and the process. The questions asked and answered are: "Who shall teach critical life issues?" "How shall ethics be integrated into the program of the student health professional?" and "How shall controversial issues be taught?" Chapter seven offers a "Teaching Model for Abortion" and a case study. 237 pages.
I would like to express my appreciation to three librarians who aided me in my research, Viola Riley, LaVonne Killick, and Karen Ambrose. I sincerely thank the members of my committee--Father Walter Krolakowski, S.J., Chairman; Dr. John Wozniak; and Dr. Rosemary Donatelli. I especially thank Father Krolakowski for his encouragement, advice, and personal concern.

I thank my husband and three sons for helping with the household chores, being quiet while their wife and mother studied, and offering their love and support during the writing of this paper. A special thank you to my mother, Anna Panek, for always standing in for me.
VITA

The author, Evelyn G. Hartigan, is the daughter of Max Panek and Anna (Lewandowski) Panek. She was born July 9, 1934, in Chicago, Illinois.

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CHAPTER ONE

INTRODUCTION

Adult men and women, freely entering the nursing profession, must acquire knowledge and skills in the humanistic as well as the technical sciences. Their goals are to preserve health, to prevent disease, and to care for the ill and dying. In these pursuits they are called upon to counsel, guide, and instruct their clients in situations involving life issues. Rebecca Bergman, Associate Professor of Nursing, and Head of the Nursing Department at Tel-Aviv University, Tel-Aviv, Israel, states:

Nursing as a health profession is faced with ethical issues on two levels: on the policy level where nursing, together with other groups, must face issues and participate in the decision-making for guidelines or laws; and in daily practice on a one-to-one relationship that has to be resolved in the here and now.1

This paper focuses on the second level—ethics in daily practice, ethics on a one-on-one relationship, and ethics in the here and now where issues need to be resolved.

In chapter one, life issues will be defined. In preparation for a fuller discussion of life issues, chapter one will define nursing and the scope of nursing practice. A brief overview of the history of

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nursing will provide the background needed to understand the relationship of the nurse to life issues.

This relationship will form the basis for the statement of the problem. The problem has developed due to: (1) new possible ethical and moral choices; (2) a tradition of non-teaching, non-preparation; and (3) a growing consciousness of the nurse's responsibilities.

Louise B. Tyrer, in an article, "The New Morality, Ethics, and Nursing," supports these three causative factors:

With a change in the laws of many states concerning abortion and sterilization, many nurses are confronted with the necessity of making additional ethical decisions. Medicine and nursing are two disciplines that of necessity are based on scientific methods which generally call for the use of absolutes in dealing with health problems. Ethics, however, refer to the direction of conduct and to the guidance of the human act and are not absolute. . . . The nurse who attempts to use only her scientific training to determine ethical conduct will be in a quandary because seldom is there empirical evidence available to support her decision—no matter what it is. 2

Chapter one will end with the statement of the problem.

Background of the Problem

Nursing is called upon to counsel, guide, and instruct patients (clients) in situations involving life issues. These issues cause what sociologists label "culture conflicts," because the solutions to the problems are in dispute.

"Critical life issue" could be substituted for "culture conflict." A "critical life issue" is a human problem. It causes disequilibrium in

the individual's internal or external environment. It requires a solution that is in conflict with the individual's own values and beliefs or is at odds with solutions acceptable by the majority of the population. It may require a solution within a prescribed period of time.

The emergence of bioethics and the rapid advances in the fields of science and technology have added new choices, and often radical choices, to people seeking a solution to a critical life issue. H. Tristram Engelhardt, Jr. and Daniel Callahan, of the Hastings Institute, refer to these problems as "...painful moral problems posed by advances in medicine and biology..." Engelhardt and Callahan further state: "The dilemmas of biomedicine are only one among a spectrum of moral issues evident in the sciences, the law, politics, and our educational institutions."

An example from law of such issues is the legalization of abortion. In January of 1973, the United States Supreme Court rendered a landmark decision on abortion (Roe v. Wade, Doe v. Bolton). The implications of this decision are yet to be fully realized. Decisions rendered by that same court (July, 1976) concerning the consent to abortion by the husband or the parents of a minor further complicate the issue. The question whether the individual should abort leads to such questions as: What happens to the aborted fetus? Burial? Disposal? Fetal experimentation? Further, should abortion substitute for other forms of birth control? Since scientists have not proven the ultimate safety of

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4 Ibid.
taking "the pill," perhaps abortion is a safer procedure for the pregnant woman seeking to avoid pregnancy.

Another example is euthanasia. Who decides to employ euthanasia? The person? His family? The doctor? The government? The insurance company? With the rapid increase in the field of medical technology, questions whether to continue with "lifesaving" or "heroic" measures arise with more and more frequency. Right to life? Right to death?

To further complicate the choices involved in the resolution of critical life issues, Daniel Callahan (a pioneer in bioethics), in an interview with Ira Mothner of the Saturday Review, said: "What we are asking is the ought questions--what people ought to do." 5

In the here and now, people are still faced with the age-old problems as abortion and euthanasia, but the possible choices for solution are different due to advances in science and other fields. Nursing, though, is still called upon to counsel, guide, and instruct clients--only more so now.

Conceptual and Historical Perspectives

New ethical and moral problems have arisen. Choices are no longer simple. Direction and help are no longer the prerogative of the physician. Nurses and other professionals (social workers, psychologists, family therapists, and so forth) are active contributing members of the interdisciplinary health team. To understand the role of the nurse in this team effort, a conceptual perspective of nursing is necessary.

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What is nursing? Like truth and knowledge, nursing has been defined by many people in many ways. Taber's Cyclopedic Medical Dictionary defines it as "the scientific care of the sick by a graduate, professional nurse."6 Eugenia Spalding and Lucille Notter define professional nursing as:

...an art and a science dominated by the ideal of service in which certain principles are applied in the skillful care of the sick in appropriate relationship with the patient and the physician and with others who have related responsibilities. It is concerned equally with the prevention of disease and the conservation of health. Skillful care embraces the whole person—body, mind and soul—his physical, mental and spiritual well-being. 7

Florence Nightingale called nursing the finest of the fine arts.8

As an art, it has been practiced since man began. The art of nursing involves the techniques and practical knowledge needed for giving safe, effective care to patients. As a science, it rests on a body of knowledge which is specialized and systematized into laws and principles. The scientific base has broadened greatly since the days of Ms. Nightingale. The knowledge of the nurse of today cannot be limited to the biological and physical sciences, such as biology, microbiology, anatomy, and physiology, but it must also include the social, humanistic sciences, such as psychology and sociology.

The nurse is called a "professional" nurse. Dorothy E. Johnson states that professional practice depends on at least three elements:

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6Taber's Cyclopedic Medical Dictionary, 7th ed. (1956), s.v. "Nursing."


(1) the knowledge, skill and personal qualities of the practitioner;

(2) an established process and methodology in decision-making; and

(3) the availability of a body of knowledge relevant to the management of practical problems of considerable social significance.

Thus far in this analysis nursing has been considered in a conceptual context. A short historical analysis is now appropriate.

Florence Nightingale opened the first training school for nurses at St. Thomas Hospital, England, in 1860. The opening of this training program signalled the beginning of professional nursing. At that time, nurses were "trained" rather than educated. The first training schools, attached to hospitals, built their programs on tasks to be done. The care was based on one simple principle: the physical needs of the patient. The instructors did not spend time on the more human aspects of care. The curricula did not emphasize the humanities. The nurse was not expected to be concerned about short and long-term goals for her patients. Professional competence, patients' rights, the nursing process, and nursing assessment were virtually unheard of.

Almost from the beginning, there was a conflict between the schools of nursing and the hospitals to which they were attached. They differed in the way they answered the following questions. What are the goals and objectives of the school of nursing? What is the nature of the school of nursing? Is the aim of the school service to the patient? Service to the hospital? Or is the aim of the school the education of the student nurse?

In 1876, Abby Woolsey stressed the need for nursing to be an educated and honorable profession. In 1879, the Commissioner of Education in Washington was quoted as saying, in a public address, that the training of nurses was substantially an educational work; that persons should be prepared for this responsible duty by special instruction. Isabel Stewart writes of this period: "The claim to professional status met some vigorous opposition. However, nurses were frequently warned by their elder medical brothers not to aim too high."\textsuperscript{10} In 1894, the First Annual Convention of the American Society of Superintendents of Training Schools stressed the importance of training the student and basing the entire program on the education of the student and not on the convenience of the hospital nursing service.

In 1923, the entire conflict between the schools and hospitals was best summarized by the report of the Committee for the Study of Nursing Education entitled: "Nursing and Nursing Education in the United States." The study revealed that the dual character of the training schools was the crux of the problem. The school sought to perform two functions: to educate nurses and to supply nursing service to the hospitals.\textsuperscript{11}

The conflict raged for decades and it was not until 1965 that the American Nurses' Association enunciated its official position on nursing education. In its first position paper on nursing education,

\textsuperscript{10}Isabel Stewart, \textit{The Education of Nurses} (New York: Macmillan, 1948), p. 94.

it stated that the minimal preparation needed for professional nursing was a baccalaureate degree.\textsuperscript{12} In 1975-76, the basic educational preparation of the nurse was still the subject of resolutions passed at nursing association state conventions in New York and Ohio.

Another conflict concerned who would control the hospital schools of nursing. As early as 1869, the American Medical Association urged the medical societies to take the leadership in developing the system for education of nurses and recommended that hospital schools of nursing be under the direction of physicians. Duties of the nurse and the areas of teaching would be outlined and controlled by physicians.

Historically, nursing has come a long way from its pioneering period in which nurses were under the complete direction and management of the physician. The struggle for a science of nursing, independent from the medical field, still continues today. But the nature of the struggle has changed. Emphasis is not on the traditional "doctor-handmaiden" relationship as it was in nursing's early history. Today the struggle is to identify roles—not only that of the nurse, but of the physician as well. Role identification and the need for interdisciplinary approaches in the health professions was in vogue in 1906 when the following appeared in the American Journal of Nursing:

The whole aim of the nursing movement is to better those conditions in cooperation with the great medical body so far as may be, in independence of that body if must be, the ultimate aim being a better educated class of women, a more useful and practical type of nurse with better nursing service in the homes of all the people, and a more intelligent service to the physician, but with this difference: the nurse of the future will work with the physician as his assistant and intelligent co-worker and not as his servant. 13

Former Surgeon General Stewart described the essential relationship of medicine and nursing:

Medicine is a profession, rooted in science. Its practice is the application of scientific knowledge which can become an art. . . . Nursing is the same; it is a profession, not a science in and of itself. Like medicine, it has deep roots in science, and as science advances the roots go deeper." 14

The conflicts, hotly debated, have gone from "service v. education" to "collegiate v. other types of educational programs." The General Practitioner, a medical journal, in an editorial comment has stated: "...training nurses in hospitals...always seemed to us like an equitable arrangement (the student nurse provides certain hospital services in exchange for her nursing education)." 15 Thomas Hale, M.D., cited twenty "cliches" of nursing education. One of the most outlandish is his second cliche: "Every Faculty Member Must Have a College Degree" and he writes:

In the first place, the decision that every nursing school faculty member must have a bachelor's degree is an arbitrary one. . . . It represents a perfectionist attitude that is hard to justify in the face of present-day needs. 16


In opposition, Cordelia W. Kelly writes in *Dimensions of Professional Nursing*: "It seems scarcely reasonable to expect nursing to remain fixed forever in a system of indentured apprenticeship."\(^{17}\)

According to Howard D. Neighbor, the justification for elevating nursing to professional status is not that nursing has become a new profession, but rather that changes in nursing are due to the changes in the practice of medicine. "If the nurse is to fill the void left by the demise of the family doctor, she must practice in the patient's environment—the home, the work place, or the hospital room."\(^{18}\)

Carrying on with Neighbor's concept of the new role of the nurse, Imogene King states: "As physicians became more specialized, they delegated some of their activities to nurses, and nurses accepted this responsibility."\(^{19}\) Reflecting further on changes in society and nursing, King cites that historically nursing has two roots: man's need to survive and man's need for help as an individual. Therefore, this responsibility and expanded role of the nurse are not limited to the physical needs (care and comfort) of the patient, but rather have extended to and encompass the social, emotional, and psychological needs of the individual as a person and as a member of a community.

King develops this concept of the expanded role of the nurse:

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\(^{18}\) Howard D. Neighbor, "This I Believe About Nursing Education," *Nursing Outlook* 18 (March 1970): 36.

Nurses play strategic roles in the process of human growth and development, and in helping individuals cope with epidoses of illness in the life cycle. They have an essential role in community planning for the delivery of health services to the public. As professionals, nurses deal with behavior or individuals and groups in potentially stressful situations relative to health and illness and help people meet their basic needs in order to perform activities of daily living. An awareness of the dynamics of nursing is essential if nurses visualize their role as helping individuals cope with stresses (underscore mine) related to health states and crises in the life cycle. 20

In summary, the practice of nursing has changed. The breadth and depth of its body of knowledge have changed. The environment of practice and scope of responsibility have changed. Nursing must adapt to the technological changes, and it must address itself to the medical-moral problems these technological changes engender.

Statement of the Problem

Robert M. Veatch and Willard Gaylin, Institute of Society, Ethics and the Life Sciences, the Hastings Center in Hastings-on-Hudson, New York, write:

The scientific and technological breakthroughs of the last few decades present ethical dilemmas (extending from dramatic to everyday) which physicians of previous generations never had the opportunity to face—and they present them at a rate which staggers the moral sense. 21

Nurses are faced with these same ethical dilemmas. It is not that the health professions are faced with new problems (for abortion and euthanasia are age-old) but rather the choices for solution are new and often radical.

20 Ibid., p. 84.

Medicine has recognized the need to change the educational content of its programs. Robert M. Veatch and Sharmon Sollitto cite the fact that new medical techniques have thrust "obviously ethical questions on physicians, patients, and others interested in the provision of health care." Such procedures as transplants, abortions, euthanasia, and fetal experimentation are all issues and problems faced increasingly by the health professions and their patients. It is further recognized that scientific progress cannot be separated from values and beliefs. Veatch and Sollitto feel that this inability to separate science and value choices is the cause of the tremendous growth of medical ethics teaching. In their study, Veatch and Sollitto ask such questions as: Can medical ethics be taught? Who should teach medical ethics?

Who shall teach medical ethics? In medicine, ethics has been mainly taught by physicians, ethicists interested in medicine, and hospital chaplains. Nursing education has followed this same route. Ethics has been taught by physicians, chaplains, sociologists, and nurse faculty members interested in the subject. Helen Creighton, a nurse-lawyer, who is Professor of Nursing at the University of Wisconsin-Milwaukee, writes that:

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it is interesting to note that the graduates of today's associate and baccalaureate degree programs are not generally familiar with the American Nurses Code of Ethics, the International Council of Nurses Code of Ethics, the Nightingale Pledge or related material. The additional courses in sociology, psychology or, perhaps, human sexuality or urban affairs that we have substituted for religious and ethical instruction leave a void. 23

Leah Curtin, editor of the National Newsline, asks:

"How long are we to teach medicine, law, nursing, sociology, etc. without providing truly adequate courses in ethics and life values? Do we have an obligation to provide students with at least the 'tools' by which to make value judgments, when the decisions they will be making are going to profoundly affect the future life of other human beings?" 24

Others do not feel that scientific advances have presented any new problems. During the 1968 Senate hearings on the establishment of a National Advisory Commission on Health Science and Society, geneticist Arthur Kornberg, a Noble laureate, testified that in his judgment there were no new ethical or moral problems arising from the developments in his field. "Such a commission," he said, "would have as its only use the education of the public on the need for more research money for scientists." 25 But James Nelson disagrees with Kornberg and writes:

23 Helen Creighton, "Moral and Legal Issues--Nursing Judgments," The Changing Role of the Hospital and Implications for Nursing Educa-


In the years since 1968 a great deal has happened. More people are aware that there are indeed new ethical and moral problems arising in the biomedical fields. Furthermore, there is an increasing recognition that nonmedical people not only have a great stake in what happens in the laboratory, the hospital, and the clinic, but that they also have an obligation to be informed and to enter into the processes of ethical reflection on these matters. For what is at issue is not simply technical medicine, but the human dimensions and qualities of that medicine. 26

Thus far, the ethical considerations of instruction on critical life issues have not been formally taught in the professional schools of nursing. The need for the development of guidelines and curricula in this area is evident and acute. Medicine has fared somewhat better in this area than nursing. The Hastings Center, a leader in medical ethics, trains medical faculties to set up courses in medical ethics and offers an internship program at the Institute. Nurse faculties and nursing students do not have this same opportunity at the Institute.

Nursing, the "caring" profession, has always been acutely aware of the human side of the patient. The task is now to prepare its practitioners to expand their knowledge base. It is evident that nursing education and nursing educators must change the curriculum in the area of medical-moral problems to meet the needs of a highly technical, fast-paced society. Society demands that the health professional be not only knowledgeable in the healing sciences, but also knowledgeable in the humanistic sciences and their application. If the professional nurse is expected to teach and counsel his/her clients on critical life issues, then the ethical considerations, the

26 Ibid.
rights and obligations of instruction, must be an integral and necessary part of the basic preparation of all nurses.

The frame of reference for this study is the ethical considerations, the rights and obligations of instruction, involved in the teaching and counseling of critical life issues. In this limiting context, the purpose is:

1. To study the relationship between the nurse and her patients (clients, consumers) and the rights and obligations which arise from this relationship.

2. To study the relationship between nurse-faculty and nursing students and the rights and obligations which arise from this relationship.

3. To study the rights and obligations of instruction of the nurse-teacher as a teacher and as a clinical teacher in a professional health setting.
CHAPTER II

CRITICAL LIFE ISSUES--ABORTION

In chapter one, critical life issues were defined. Critical life issues are human problems which cause disequilibrium within the individual's internal or external environment. A solution to these problems is in conflict with the individual's own values and beliefs or is at odds with solutions acceptable by the community at large. Often, the issue must be resolved in a certain period of time. Two issues which are currently causing internal and external environmental disequilibrium to many humans are abortion and euthanasia. The first of these will be analyzed in this chapter; the second, in chapter three. First the issue will be defined, and secondly, its religious, legal, and other implications will be discussed. There are many other life issues which are critical, such as fetal experimentation and behavior modification, but only abortion and euthanasia will be discussed.

Definition

Defining abortion presents little if any problem. The majority of people, professional and lay, agree to the definitions outlined in this paper. Before defining abortion, the line between what is abortion and what is not abortion, but delivery, should be drawn.
Basically, any interruption of a pregnancy before viability is called abortion, regardless of cause. Interruption of pregnancy after viability is delivery, regardless of whether the infant is alive or dead, immature, premature, or full-term.

Bearing this distinction in mind, abortion can now be defined. In 1956, abortion was defined as "the termination of pregnancy before the term of viability, i.e., before the 28th week, the fetus measuring 35 cm. or less, and weighing less than 3½ lb. (1500 Gm.)." In 1975, Anderson, Camacho, and Stark defined abortion as the termination of pregnancy before viability of the fetus is reached. Viability is defined by them as the ability of the fetus to survive outside the uterus. Specialized supportive care has enabled 500-gram babies to survive so that, when "viability" is used in the definition of abortion, it is synonymous with the fetus reaching 500 grams, rather than the 1500 gram minimum of 1956.

The Boston Children's Medical Center, in a publication written for parents, defines abortion in this same vein:

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1Taber's Cyclopedic Medical Dictionary, 7th ed. (1956), s.v. "Nursing."

In modern medicine the dividing line between, on the one hand, spontaneous abortion (or miscarriage, to use the layman's term) and, on the other, premature delivery has become somewhat vague. Dramatic advances in the care of prematures enable us now to save little babies who once might have been described as aborted fetuses. For practical purposes, we can make a distinction by defining abortion as the termination of pregnancy in its first twenty weeks, when the fetus weighs five hundred grams (approximately one pound) or less. 3

Fitzpatrick, Reeder, and Mastroianni sum up the definition of abortion and the questions of weight and viability thusly:

Abortion is the termination of pregnancy at any time before the fetus has attained a stage of viability, that is, before it is capable of extrauterine existence.

It is customary to use the weight of the fetus as an important criterion in abortion. Infants weighing 1,000 Gm. (2 lbs., 3 oz.) or less at birth possess little chance for survival, whereas those above this weight have a substantial chance of living. Thus, many authorities regard a pregnancy which terminates when the fetus weighs 1,000 Gm. (about 28 weeks of gestation) or less an abortion. On the other hand, a small percentage of infants weighing 1,000 Gm. or less do survive. Modern advances in the management and care of premature infants have made it possible for smaller and smaller infants to survive, so fetuses weighing only 800 to 900 Gm. (1 lb., 13 oz. to 2 lbs.) may live. For this reason many authorities now maintain that fetal weights of 1,000 Gm. or less but more than 400 Gm. is classified as immature, and that fetal weight of 400 Gm. (about 20 weeks of gestation) or less constitutes an abortion. It is obvious, therefore, that how the termination of pregnancy is classified in different hospitals will depend wholly on the interpretation to which they subscribe. In summary, the following definitions are generally used. The termination of pregnancy at any time when the fetus weighs 400 Gm. or less is defined as an abortion. Infants weighing between 401 and 1,000 Gm. are called immature.

A premature infant is one born after the stage of viability has been reached but before it has the same chance for survival as a full-term infant. By general consensus, an infant which weighs 2,500 Gm. or less at birth is termed premature; one which weighs 2,501 Gm. (5½ lbs.) or more is regarded as full term. 4

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Therefore, it is generally agreed that abortion is the termination of pregnancy before the fetus reaches viability, 400 Gm. There are two sub-classifications of abortion: spontaneous and induced. Spontaneous abortions occur as a result of stressors within the homeodynamic systems, while induced abortions occur directly as a result of mechanical or medicinal agents. Induced abortions can either be medical, under legal jurisdiction, or criminal, outside the legal realm.

As stated previously, the defining of abortion presents little if any problem. But what can and often does cause problems are the methods by which abortion can be induced. Patricia McCormick, writing for Health Care Dimensions, offers the following comment about the methods used to abort a pregnancy:

...while the psychological effects of abortion performed in different states of pregnancy and using different aborting procedures have been virtually unexplored, some observers believe that there may be substantial psychological sequelae associated with late pregnancy termination. Bracken and Swigar suggest that this may result from the trauma of the saline infusion procedure itself and the removal of an active fetus which has already become the object of some psychological investment.

Up to the twelfth week of pregnancy, usually two methods are used: (1) suction; and (2) dilatation and curettage (D&C). Anderson writes of this period:

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5Anderson et al., The Childbearing Family, 2:78.

At this time in pregnancy (up to the twelfth week of pregnancy), the reality of the pregnancy itself is often vague and there is no sense of a baby. Thus, the mother has to deal with the feelings of loss of the state of pregnancy rather than loss of a baby. Depending on the stressors that caused the mother to decide to terminate the pregnancy, the mother may be able to adapt more effectively to those stressors now that the crisis state of pregnancy is over. . . .

A third method of inducing abortion is the use of a saline solution which is administered into the uterine cavity through the abdominal wall. Saline solution stimulates the uterus to contract, and thus to expel the products of conception. The mother is awake during this procedure. The entire procedure (from injection to expulsion) takes approximately 32-48 hours. Anderson states that "during the time that the mother is in the hospital for a termination of pregnancy, she does not like to be left alone. She usually finds it helpful to talk about her decision and about her future plans in an accepting atmosphere."8

Medicine is constantly searching to find different and more effective, safe methods of aborting pregnancies regardless of the length of gestation. The Boston Children's Medical Center publication notes:

Methods of inducing abortion have been known for centuries and practiced all over the world. Some societies have not merely condoned but encourage abortion. In contrast, the Christian tradition has condemned it. Both the laws of the church (notably the Roman Catholic Church) and the criminal law of the state have expressed this condemnation. In its extreme position the church has regarded abortion as the murder of a human being, the fetus. The secular criminal law, however, while taking its lead from the church, has not prosecuted on those terms. In practice, the police make arrests only when a woman dies of a bungled abortion or when some crusading group with political power demands action.

7Anderson et al., The Childbearing Family, 2:82.

8Ibid., p. 84.
While we now seem to be on the threshold of drastic change, all the states of the United States had until quite recently restrictive (some would say punitive) laws regulating induced abortion. . . .

...Contrary to general belief, unwed mothers do not make up the majority of women who resort to abortion. The evidence suggests that as many as four out of five aborted women are married and have more than one child. 10

With this background information on the technical definition of abortion, some other facets of the problem may now be considered.

Legal Aspects

B. James George, Jr. wrote in David F. Walbert and J. Douglas Butler's Abortion, Society, and the Law:

Laws regulating the sexual behavior have no peers when it comes to stirring up intense emotional reaction; when the element of life itself combines with human sexuality, as it does only in the context of abortion, the intensity of emotional disagreement and conflict is compounded. In the short span of years since 1966, the starting date of a definite trend toward liberalization of abortion laws, proponents of liberalized abortion have gained significant ground on both the legislative and judicial fronts. Despite these successes, the battle over abortion law reform or revision remains intense. And this battle is likely to continue, because there is fundamental and probably irreconcilable disagreement over the primacy of personal and social interests and the extent to which these interests are to be effectuated through the law. . . .

...Any discussion of abortion necessarily revolves around four different foci: the fetus itself, the pregnant woman, and family into which the expected child will be born, and the surrounding community. 11

9The United States Supreme Court legalized abortion (January 1973) in the year following this report.

10The Boston Children's Medical Center, Pregnancy, p. 417.

It is readily seen that abortion is a tremendously emotional issue: one that is age-old; and one that will never be resolved to the satisfaction of all those who are involved in the issue.

Historically, abortion is as old as history. Glanville Williams writes that both Plato and Aristotle approved abortion for the purpose of population control.12 Williams in his historical account of the law and abortion further points out that "this abortion goes back to an ancient speculation as to the time when life commenced...Hippocrates put the two periods at 30 [for male] and 42 [for female] days..."13 Today, the question of when human life begins still remains just as unsettled as it was when history was first recorded.

But the laws governing abortion have changed drastically, if not with uniformity and clarity. Robert E. Hall sketches the progress of the abortion laws in the foreward of Walbert and Butler's book. Some of the legal landmarks he points out are:

"1. In 1967 the first three new abortion laws were enacted.
A. Colorado led the way with the statute permitting abortions for protecting and preventing risk of fetal deformity, and in cases of rape and incest, as recommended by the American Law Institute (ALI) in 1959. This law set no time limit in pregnancy.
B. North Carolina was next to pass an ALI law, which also set no pregnancy time limit but included a residency requirement.
C. California wrote a law with a twenty-week time limit but excluded the fetal-deformity part.

"2. Nine other states passed similar ALI laws and all had the same lack of uniformity as did the first three. The only similarity between all the laws was the requirement that the abortion be performed by a physician. The laws varied in such things as:

13Ibid., p. 149.
Hall writes that numerous other variations existed in both the laws themselves and their implementation by the medical profession. Some of these differences have no significant effect, but others do. It was clear though that there was a definite reform movement in progress. But in 1971, for the first time since 1967, no new abortion legislation was passed. Many abortion reform measures were considered, but all were rejected by the various state legislatures. Hall writes of this period "...the legislators are sitting back, waiting for a decision from the courts."\textsuperscript{15}

The wait was not long. On January 22, 1973, the United States Supreme Court rendered its historic decision on abortion (Doe v. Bolton, Roe v. Wade). Richard A. McCormick writing in Theological Studies of this period says: "Whatever one's opinion of the Court's action, one thing is clear: in \textit{Wade} and \textit{Bolton} we are dealing with 'one of the most controversial decisions of this century,' as the Hastings Report phrased it."\textsuperscript{16} McCormick goes on:

\begin{quote}
Abortion is a matter that is morally problematic, pastorally delicate, legislatively thorny, constitutionally insecure, ecumenically divisive, medically normless, humanly anguishing, racially provocative, journalistically abused, personally biased, and widely performed. \textsuperscript{17}
\end{quote}

McCormick lists these critiques of the 1973 Supreme Court decision:

\begin{itemize}
\item [\textsuperscript{15}]Ibid., p. ix.
\item [\textsuperscript{17}]Ibid.
\end{itemize}
David Goldenberg, in a good review of the legal trends leading to Wade and Bolton, takes no moral position but faults the Court on legal grounds. For instance, on the basis of lack of direct references to the unborn in the Constitution, the Court asserts that the fetus is not protected by constitutional guarantees. 18

Daniel Callahan rightly contends that the Court did for all practical purposes decide when life begins: not in the first two trimesters, possibly in the third. 19

Dr. André Hellegers (Kennedy Institute for the Study of Reproduction and Bioethics) resents...the falsification of embryology for the purpose of avoiding the fundamental question: "when shall we attach value to human life?" Hellegers argues that the basic question is not, when does life begin? It is, when does dignity begin? The Courts fudged this. Hellegers states "they have used terms like 'potential life' trying to say that life wasn't there, when the reason for saying that life wasn't there was because they didn't attach any value to it. The abortion issue is fundamentally a value issue, not a biological one." If the Court is to be truly consistent Hellegers contends, there is no reason to worry about the health of the fetus. This implies that experimentation on the fetus in utero is perfectly acceptable. It also renders uncomfortably inconsistent the FDA's strict rules about drugs during pregnancy. 20

...John Noonan raises several serious questions. First, if the liberty to procure termination of pregnancy is "fundamental" and "implicit in the concept of ordered liberty," how is it that this liberty has been consistently and unanimously denied by the people of the United States?. . .Second. . .Noonan argues that the Court, in spite of its contrary allegations, allowed abortion-on-request; for the viable fetus was denied personhood and the state was granted the right to proscribe abortion in the third trimester "except when it is necessary to preserve the life or health of the mother." Then the Court describes "health" as involving a medical judgment to be made "in light of all the factors--physical, emotional, psychological, familial, and the woman's age--relevant to the well-being of the patient. All these factors may relate to health." Briefly, in the third trimester a child may be aborted

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for the mother's well-being. As Noonan reasonably notes, "what physician would now be shown to have performed an abortion, at any time in the pregnancy, which was not intended to be for the well-being of the mother?"

Noonan's next objection is aimed at the Court's schizoid style of judicial interpretation. That is, the Court was evolutionary in its reading of the notion of liberty, but utterly static and constructionist in its interpretation of the term "person." Finally, Noonan, with Callahan, argues that the Court was inconsistent on its own competence. "The judiciary," Wade reads, "is not in a position to speculate as to the answer as to when life begins." Yet Texas is said to be wrong in "adopting one theory of life." Clearly, if Texas is wrong, then the Court does indeed know when life begins, especially "meaningful life." 21

P. T. Conley and Robert J. McKenna accuse the Court of a "foray into the legislative domain." After confessing its own incompetence about life, the Court should have, on this basis, declared the matter unjusticiiable. . . . After criticizing the Court's utilitarian valuation of life, its inconsistencies and intellectual sloth, they contend that while the unborn's right to life is not explicit in the Constitution, still, unlike the right to abort, it is recognized by law, custom, and majority opinion and could rather easily be inferred from the Declaration of Independence. There it is stated that "all men are created equal and endowed with inalienable rights." But creation is traditionally associated with conception. They conclude that "the decision was patently unsound from either a logical, biomedical, moral or legal perspective. 22

Blanchard and Doerr state that "the Court proved in long and scholarly footnotes that the Church had permitted abortion for centuries." 23 Footnotes may be lengthy, but whether they are scholarly is another question. The footnoting in Wade does, indeed, appear imposing and could be very deceptive. But John R. Connery, S.J., in a careful study of the animation, nonanimation debate, notes that "from the beginning of Christianity abortion has been condemned as morally wrong. The only issue was one of classification." 24 As for the Court's historical presentation, Connery says that it "is too fragmentary, misleading and erroneous to be of any


24 Ibid.
real value." His conclusion: "Rather than rely on such a travesty, it would have been far more honest if the honorable justices admitted openly that they were simply departing from the past, and not just the past that began in the nineteenth century. The decision has no precedent in either Christian moral or legal tradition." Those familiar with both the care of Connery's research and the softness of his critical touch will see this particular salvo as a deathblow to the Court's pretensions to historical scholarship.

Robert M. Byrn accuses the Court of inartistic and unpersuasive historical revisionism "before it could administer the fatal blow." The controversy is about the value of human life, and the Court refused to protect unborn children "because there is a controversy over whether their lives are of value--whether they are 'meaningful.'" Social convenience and utility decided the day.

As William J. Curran, J.D., of the Harvard Medical School, notes, "The abortion decisions are already under a good deal of attack by constitutional lawyers, not so much for their result as for their reasoning."26

In summary, the critiques available thus far attack the Court's reasoning from almost every conceivable point of view: logic, use of history, anthropology.27

Thus far, the case of the opposition has been given, but not all were against the Supreme Court ruling. Time magazine called it "A Stunning Approval for Abortion" and wrote "thanks to the Texas waitress [Roe] and the poverty-striken Georgia housewife [Doe], every woman in the U.S. now has the same right to an abortion during the first six months of pregnancy as she has to any other minor surgery."28 The Time article continues:

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The ruling was rooted in the Court's view of the right to privacy. Blackmun [Justice Harry] held that such a right has now become an indivisible part of every American's "liberty," which is specifically protected by the due-process clause of the Fourteenth Amendment.

...A fetus, he added, is not a person under the Constitution and thus has no legal rights to life. ... 29

Supporting the decision long before it came about was an editorial in the Minnesota Medicine journal written in 1969. In the editorial section, "You May Be Right," in an editorial captioned "Abortion or Compulsory Pregnancy?" Robert B. Benjamin wrote:

Minnesota's antiquated abortion law should be repealed or liberalized. The present law, last changed in 1886, was established at a time when women played a far more subservient role in society and had little or no influence on law-making—even that having to do with their own bodies. If men, being the law-givers, were the child-bearers and child-tenders in our society, all proscriptions on abortion would undoubtedly have been removed centuries ago.

The question whether abortion is moral or immoral has been strongly colored by generations of philosophers and theologians (all men) indoctrinated in the ancient role of male dominance, and it is their sonorous voices that have established our present punitive abortion laws. Our present law impresses the philosophy of a minority upon all our women.

...Hopefully, the day will come when a decision regarding abortion will be left to the pregnant woman. 30

The Lancet also writes in support:

The fundamental question in all abortion legislation is the degree of control which the community or Government should exert over the wishes of the pregnant woman herself. ... 

29Ibid.

30Robert B. Benjamin, "You May Be Right--Abortion or Compulsory Pregnancy?" Editorial in Minnesota Medicine 52 (March 1969): 455.
On January 22, the United States Supreme Court ruled that the abortion laws of the State of Texas and of Georgia are unconstitutional and therefore invalid because they imposed restrictions upon the rights of the pregnant woman. 31

Supporting the abortion movement from another angle was an editorial by Robert B. Benjamin, Chairman of the Medical Advisory Committee of Planned Parenthood of Minnesota, in the Wisconsin Medical Journal:

Abortion reform has not produced large numbers of depressed and guilt-ridden women. . . .

. . .Skilled and humane counseling may reduce psychiatric problems related to abortion to near zero. One of the principles of counseling women with unwanted pregnancies is to allow the women involved to make their own decisions. . . .

. . .Opponents of abortion reform cling to the concept that abortion results in killing a "human being." For thousands of years philosophers have argued as to "when life begins". . . .

. . .Now that safe, legal abortions are a possibility, laws that abrogate a woman's rights to safely terminate her pregnancy must be regarded as sexist. . . .

. . .Finally, we ask the wrong question when we say, "Should women be allowed to have abortions?" Women have always obtained abortions. Even conscientious women, following contraceptive failures, have had to resort to hazardous illegal abortions. The question we now should ask is, "Shall women be allowed to obtain safe legal abortions?" 32

Those supporting abortion have defended the right of a woman to control her own body and make her own decisions. But one other person needs to be mentioned at this time, and that person is the physician. Before the Supreme Court decision, physicians were pushing for the right to make the decision whether or not to legally terminate a pregnancy. They were in favor of rather broad guidelines in this area.


without outside interference. Not all people agree with this omnipotent role of the physician. In the "Editor's Comment" section of Child and Family, the editor, Herbert Ratner, makes the following observations about the physician's role from a broader frame of reference:

The Vietnam war exemplified an old truth: that no science or discipline is an island unto itself, that some sciences are subaltern to others, and that in the hierarchy of sciences, ethics and/or theology are architectonic and controlling. Medicine does not escape this hierarchy; nor can the physician, any more than the militarist, claim autonomy for his art.

This truth is most critical to the abortion controversy. In an abortion, unlike an appendectomy, the physician is not dealing with simply a part of the body, but with a separate organismic whole whose individual destiny of maturing personhood is unequivocal. Semantics and sophistications not withstanding, both the mother seeking an abortion and the physician performing an abortion know they are getting rid of a baby; and abortion is not so much a matter of what is being done to her, the mother, but what is being done to the child within her.

Conferences on abortion which customarily include sociologists, lawyers, ethicists and theologians, as well as physicians, acknowledge that the relationship of the sciences is paramount in the abortion problem. Pro-abortionists erroneously deny this relationship when they argue that "pregnant women together with their physicians merit the right to make private abortion decisions" (Lonny Myers, M.D., Cultural, Medical and Psychological Aspects of Abortion, University of Chicago Conference on Abortion, April 28-30, 1968) or that abortion is "primarily a medical responsibility" (American College of Obstetricians and Gynecologists, Medical World News, May 24, 1968). Further, the very existence of abortion legislation, whether stringent or relaxed, to specify which abortions are permitted and which are not permitted confirms the fact that the decision concerning who is to live and who is to die through direct killing transcends the authority of the medical art. 33

Also questioning the omnipotent role of the physician, Rabbi Immanuel Jakobovits, Jewish medical authority, writes that a position

approving the physician's increased legal control over the termination of pregnancy cannot be upheld. The judgment that is required here, while it must be based on medical evidence, is clearly of a moral nature. Jakobovits fills in the issue stating:

The decision on whether, and under what circumstances, it is right to destroy a germinating human life depends on the assessment and weighing of values, on determining the title of life in given cases. Such value judgments are entirely outside the province of medical science. No amount of training or experience in medicine can help in ascertaining the criteria necessary for reaching such capital verdicts, for making such life-and-death decisions. Such judgments pose essentially a moral, not a medical, problem. Hence they call for the judgment of moral, not medical, specialists.

In demanding that they should have the right to determine or adjudicate the laws governing their practice, physicians are making an altogether unprecedented claim, one not advanced by any other profession. Lawyers do not argue that, because law is their specialty, the decision on what is legal should be left to their conscience. And teachers do not claim that, since they are professionals competent in education, the laws governing their work should be administered or defined at their discretion. . . .

A physician, in performing an abortion or any other procedure involving moral considerations, such as artificial insemination or euthanasia, is merely a technical expert; he is no more qualified than any other layman to pronounce on the rights or legality of such acts, let alone to determine what these rights should be, relying merely on the whims or dictates of his conscience. The decision on whether a human life, once conceived, is to be or not to be, therefore, properly belongs to moral experts, or to the legislatures guided by such experts. 34

Rabbi Jakobovits brings forth another dimension of the physician's role, the relationship of the medical profession to Judaism. He points out, in the preface of his book, Jewish Medical Ethics, that of all practical sciences, it is pre-eminently medicine with which Judaism, historically and intellectually, enjoys a natural kinship and "to which Jewish law is best qualified to address its reasoned,

pragmatic rules of morality."35 For many years, physicians and rabbis often merged their professions into one, in a common effort for the betterment of life. "The perplexities of our age challenge them to renew their association in the service of human life, health and dignity. Indeed they challenge Judaism itself to reassert its place as a potent force in the moral advancement of humanity."36

Robert E. Hall, M.D., Associate Editor of the American Journal of Obstetrics and Gynecology, has written extensively on the subject of abortion and was the President of the Association for the Study of Abortion in 1968. Of the role of the physician in abortion, he wrote:

Abortion is a medical issue only because it is the doctor who wields the necessary instrument. He is no better able to judge who qualified for an abortion than the patient's minister, the patient's lawyer, or the patient herself. 37

In summation, those who endorse and support the Supreme Court decision of January, 1973, legalizing abortion have based their arguments on the rights of privacy and control over one's body. The consents and opinions of others (physician, spouse, parent) are therefore not necessary according to most proabortionists. The proabortionists have not addressed the issue of the right of the unborn to life or the question of when does a fertilized egg (zygote) become a human? B. A. Brody, of the Massachusetts Institute of Technology, in an article in the Journal of Philosophy, writes:


36Ibid.

One of the most frustrating aspects of discussion about abortion is the way in which they rapidly turn into a discussion of the status of the foetus and of whether destroying the foetus constitutes the taking of a human life. Since these latter questions seem difficult, if not impossible, to resolve upon rational grounds, frustration results. It therefore seems desirable to find aspects of the abortion problem that can be resolved independently of the status of the foetus problem. One such possibility is the question of whether there should be a law against abortions performed by licensed physicians upon the request of the mother (or perhaps the parents). 38

So the proabortionists have not addressed the "human life" question, nor do they seem to desire to do so. The main thrust of their argument is really the liberalization of the woman and her rights.

The opponents of the decision have attacked it mainly from a legal standpoint. They have questioned the decision from a historical, legislative, judicial, and constitutional frame of reference. The decision has been further attacked on the grounds that it leaves too many questions unanswered in its initial pronouncements, such as, what is the role of the private hospital? Who is financially responsible for the costs of abortion? What are the rights of the father? 39

Although not discussed in this section of the paper, one group of opponents which must be mentioned is the "Right to Life" proponents. Their major thrust can best be analyzed in the religious aspects of the problem and these will be considered in the next section. With the legal considerations in mind, the religious aspects of the abortion issue may now be addressed.


39In 1976, the United States Supreme Court ruled that the husband's consent is not necessary for an abortion to be performed. It is probably safe to apply this decision to the father—whether married to the mother or not.
Religious Aspects

Following the abortion decision by the Supreme Court, the Administrative Committee of the National Conference of Catholic Bishops rejected the decision as "erroneous, unjust, and immoral." The committee affirmed that Catholics must oppose abortion and that Catholics would be in a state of excommunication if they obtained or performed an abortion. "In effect, the court is saying that the right of privacy takes precedence over the right to life," but that "this opinion of the court fails to protect the most basic human right—the right to life. Therefore, we reject this decision of the court because as (Pope) John XXIII says (in his Peace on Earth encyclical): 'If any government does not acknowledge the rights of men or violates them...its orders completely lack juridical force.' The committee statement goes on:

The court has apparently failed to understand the scientific evidence clearly showing that the fetus is an individual human being whose prenatal development is but the first phase of the long and continuous process of human development that begins at conception and terminates at death. Thus, the seven-judge majority went on to declare that the life of the unborn child is not to be considered of any compelling value prior to viability, i.e., during the first six or seven months of pregnancy, and of only questionable value during the remaining months... . .

. . . We find that this majority opinion of the court is wrong and is entirely contrary to the fundamental principles of morality. Catholic teaching holds that, regardless of the circumstances of its origin, human life is valuable from conception to death because God is the Creator of each human being... . . No court, no legislative body, no leader of government, can legitimately assign less value to some human life. Thus, the laws that conform to the opinion of the court are immoral laws... . .Whenever a conflict arises

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40 "Bishops' Administrative Committee Rejects Abortion Ruling," Hospital Progress 54 (March 1973): 83.
41 Ibid.
between the law of God and any human law, we are held to follow God's law. 42

Along with the issuance of this statement, Bishop Edward D. Head, bishop of Buffalo and the chairman of the Committee on Health Affairs, United States Catholic Conference, issued the following pastoral applications as adopted by the Committee:

"1. Catholics must oppose abortion as an immoral act. No one is obliged to obey any civil law that may require abortion.

"2. Abortion is and has always been considered a serious violation of God's law. Those who obtain an abortion, those who persuade others to have an abortion procedure are guilty of breaking God's law. Moreover, in order to emphasize the special evil of abortion, under Church law, those who undergo or perform an abortion place themselves in a state of excommunication.

"3. As tragic and sweeping as the Supreme Court decision is, it is still possible to create a pro-life atmosphere in which all, notably physicians and health care personnel, will influence their peers to see a value in all human life, including that of the unborn child during the entire course of pregnancy. We hope that doctors will retain an ethical concern for the welfare of both the mother and the unborn child, and will not succumb to social pressure in performing abortions.

"4. We urge the legal profession to articulate and safeguard the rights of fathers of unborn children, rights that have not been upset by this Supreme Court opinion. 43

"5. We praise the efforts of pro-life groups and many other concerned Americans. ..." 44

The Catholic Church historically has opposed abortion. John F. Dedek, in Human Life, writes that from the first centuries Christians condemned abortion in general. (Therapeutic abortion as a means to

42Ibid.

43This plea was disregarded in July 1976, when the United States Supreme Court ruled that the husband's permission was not necessary for an abortion.

44Bishop's Committee, p. 96a.
save the life of the mother was met with greater tolerance.) Dedek points out the difference theologically between direct and indirect abortion:

Theologians generally taught that the abortion must be indirect, not directly willed. Many considered an abortion or embryotomy indirect as long as one's subjective intention was directed to the good to be gained rather than to the death of the fetus. . . .45

He adds:

... Historically, socio-economic reasons for abortion were not important considerations in theological casuistry. ... Sanchez did introduce some socio-economic reasons, and he was never re-proved by the Holy See. . . .

... To this day the Holy See has never explicitly condemned abortion in cases of either rape or incest. But the absolute condemnations of Pius XI and Pius XII certainly include these cases implicitly.

... It seems fair to conclude that Protestant teaching on abortion today reflects more accurately the historical Christian tradition. Abortion is condemned generally speaking, but there is divergence of views about special cases and a general allowance for medical and some socio-economic reasons which would justify an abortion.

... The Church's recent teachings can be described as authentic noninfallible doctrine. But the Church is not officially committed to it in quite the same way as it is committed to its teaching on contraceptions. ... the Catholic teaching on contraception dates back to the earliest times and practically speaking has been always and everywhere the same. But the view that there is absolutely no indication for abortion, whether medical, social, economic or moral, has enjoyed its privileged position in the Church only during very recent years. 46

Not all agree that the Church's position on abortion has historically always been the same. Robert E. Hall, expressing a non-Catholic view on abortion writes:


46Ibid., chap. 2 passim.
The position of the Roman Catholic Church rests upon its modern-day assumption that the fetus is a human being and its destruction murder. (Bear in mind that, with the exception of a three-year period in the sixteenth century, the Church did equate abortion and murder till 1869.) 47

Writing a rebuttal comment to an article entitled "Why Therapeutic Abortion?" by Theodore Watson in Minnesota Medicine, Raymond J. Albrecht, M.D., states (and in apparent opposition to Hall's statement):

There is no historical evidence that the Roman Church ever condoned or acquiesced in abortion in any stage of gestation. Theologians have defined feticide as murder, if the fetus has a human soul. Varying estimates of the moment of ensoulment originate from earliest times. Fourth century theologians, such as St. Basil and St. Gregory of Nyssa, held that the soul was infused at the time of conception and that all abortion was homicide. This concept is not exclusively a "relatively modern one."

In two ways the Church Fathers have proscribed abortion before ensoulment or without direct reference to ensoulment. Since the development of the child from conception to birth terminates with development of human life, direct interference with this process is forbidden by the Natural Law; secondly, by the application of the Principle of Indeterminancy, human life may be present at any point in gestation, and the abortionist may take full responsibility for this possibility.

The Papal Bull, Effraenatam by Sixtus V, issued on October 29, 1588, defined severe ecclesiastical penalties for abortion as well as for contraceptive practices. According to Noonan, Gregory XIV repealed all portions with the exception of abortion of an ensouled, forty-day fetus in the Papal Bull, Sedes Apostolica, May 3, 1591. This did not in any sense allow abortion earlier than forty days.

It may be a fair statement that direct abortion before ensoulment was not considered homicide by some Church Fathers (St. Augustine) and possibly a lesser evil with lesser penalties. However, it is not correct to imply that the Church ever considered early abortion anything other than a serious evil. 48

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47 Hall, Abortion: A Non-Catholic View, p. 83.
Michael V. Viola, writing in defense of the Catholic abortion stand, furnishes the following historical background:

The theological debate on abortion revolves around the arbitrary point in embryogenesis when the fetus becomes a person. . . . The Catholic Church has stood firm since 1869, stating that the fetus is to be considered a person from the moment of conception (Apostolicae Sedis of Pope Pius IV). . . . Many of the Fathers of the Church, notably St. Basil, upheld this position and had a great influence on Conciliar Pronouncements until the twelfth century.

However, during this period, St. Augustine suggested that only after "animation" (infusion of the human soul into the fetus) was abortion to be considered immoral. St. Jerome... concluded that the taking of a fetal life before the fetus was "formed" (having human physical characteristics) was only a minor sin. From the twelfth until the nineteenth century, with the exception of the extremist Pope Sixtus V (1585-1590), the distinction between the "animated" and "nonanimated" fetus persisted, abortion being tolerated only in the latter instance. The exact moment of animation in gestation could not be agreed upon, of course. . . . 49

Viola best sums the entire argument about the historical position of the Church: "Let it suffice to say that there has been considerable confusion throughout the history of the Church regarding the morality of abortion early in pregnancy." 50 In modern day Catholic teaching, the statement by the Bishop's Committee best states the Catholic thinking on abortion.

The view of the Protestant church in modern times is much more difficult to pin down. Of Protestants, George Huntston Williams, of Harvard University, writes: "...many... have lost their historic bearings in the current debate and are aware that there is at present no moral consensus among them on the question of abortion comparable


50 Ibid.
to that among Catholics."51 He elaborates:

As for those in the main religious groupings for whom religious tradition is intentionally a determinant in their professional and civic life, it is evident that traditional views embodied in responsorial and casuistic literature and in canon law are more clearly functional in the present debate on the issue of abortion in the case of Jews and Catholics than in that of Protestants. The latter, for the most part, except for Scripture, have in principle, at least, disallowed any body of religious law or tradition to be binding. Thus it is much more to the point for a historian to reach back to Moses Maimonides or Thomas Aquinas than to the relatively more recent Martin Luther or John Calvin in getting at either the subliminal or intentional religious and ethical motivations for what a contemporary American Jew, Catholic, or Protestant might say or do about the issue of abortion. 52

Of Judaism, Rabbi Martin J. Goldman writes, "I can state in two minutes the position of Jewish law in regard to criminal abortion."53 He writes:

Neither in the Bible, nor in the Mishnah and Talmud, nor in the Codes, is abortion mentioned as a penal crime in Jewish law. The only opinions expressed against abortion are found in the works of a philosopher, an historian, and a mystic. The philosopher is Philo; the historian is Josephus Flavius; and the third, the mystic, is the author of the Zohar. 54

The Covenant Code (Ex., XXI:22-23) states that if a pregnant woman is assaulted and a miscarriage occurs and "yet no harm follows," he shall pay a fine; but if any harm follows, then the regular laws of assault or homicide apply. Rabbi Goldman points out, however, from the Rabbinic interpretation of the Biblical law it is clear that the

52Ibid., p. 13.
54Ibid.
killing of a fetus in any stage of development is not considered murder and is not punishable by death in Jewish law. Of therapeutic abortion, Goldman quotes the Mishnah, "in the case of difficult birth, where the mother is in danger, one cuts up the child in her womb and extracts it member by member, because her life has priority over its life; but if the greater part of the head has emerged, one may not harm it, for one may not set aside one person's life for another."55

This ruling demonstrates that Jewish law not only sanctions embryotomy to save the mother's life, but is obligatory. Goldman concludes "you can also understand from this that only at the moment of birth does the child become a life, a being, a person."56

It can be seen that organized religion is far from agreement on the abortion issue. At the one pole is the Catholic position, which is clearly against abortion, and at the other pole, the Jewish position which, in its laws, does not mention abortion as a crime. Somewhere and everywhere on this broad spectrum of opinion lie the Protestant positions. Crucial points in the religious questions concerning abortion are the right to life (of the fetus) and the value of human life. The question of "ensoulment" and the principle of double effect make the problem more complicated. Viola writes that the Roman Catholic position in its defense of the inviolable rights of the zygote is "seemingly blind to the tragedy that an unwanted pregnancy can impose on an ill woman" and "presses for the embryo's right to any level of

55 Ibid., p. 94.
56 Ibid.
impaired existence." 57 The proabortionist, on the other hand, "fails to see in the developing embryo any degree of sacredness or need to be protected." 58 The theological debate then revolves around the arbitrary point in fetal development when the fetus becomes a person. The question then that must be asked is: What is "human"?

Moral Aspects

Dedek summarizes the dilemma of what is human life:

The question that must be asked is: What is the nature of fetal life? Is a fetus a human person, merely prehuman organic matter or something in between? This, of course, is not the only question. Once it is answered we should inquire further: What value should we attach to it? Does it have the same inviolability as mature human life or does it have less? 59

James Nelson writes that the word "human" has become one of the "most-used and least-defined terms in ethical and moral discussions." 60 Nelson makes the following observations: (1) as an adjective, "human" distinguishes our race from others of the animal kingdom; (2) negatively, we use the term to excuse our frailties: "I'm only human;" (3) positively, we use it to applaud the presence of certain qualities of life and action: "that was a human thing to do." 61

There are three basic schools of opinion on the question "when does human life begin?": the genetic school, the developmental school,

57 Viola, Abortion: A Catholic View, p. 89.
58 Ibid.
59 Dedek, Human Life, p. 63.
60 Nelson, Human Medicine, p. 17.
61 Ibid., pp. 17-18 passim.
and the social consequences school. The genetic school believes that human life begins at the moment of conception (the meeting of the sperm and egg, the zygote) or at the moment of the fixing of the genetic code. The developmental school believes that some development is necessary before the term human can be applied. When is this point in the developmental process? It is still open to debate within this school of thought. For some, it is between the first six to eight weeks of intra-uterine growth; for others, the embryo has no human status during the first two weeks of intra-uterine life, but "after this it gradually attains more human status until the time of viability (about twenty-eight weeks) when the fetus should be treated as having all the rights of a new-born child." For others, the beginning of human life is based on some criterion of brain development. The social consequences school rejects all biological data as determinative. They believe that human adults, not biological data, can decide what is human, and further, that such decisions must take into account the morality that society wants.

Callahan favors the developmental position. Callahan feels that it takes the biological data seriously and realizes that the dictates of society with regard to moral policy are important. "However, unlike the genetic school (which argues that all forms of human life must be valued equally) the developmental position leaves room for weighing the comparative values of different qualities and stages of human life.

62Ibid., p. 18.
63Ibid., p. 19.
which may be in competition in a given situation." 64 Callahan does not agree with the social consequences school that the meaning of human is a matter simply of social utility.

Nelson points out that the developmental school position leaves us in an ambiguous position about the meaning of human life: it is not purely genetic, nor is it simply based on the needs and wants of society. But he feels that this ambiguous position is desirable and has advantages. First, this position recognizes the ambiguity and value conflict that will be present in practical situations; second, it recognizes that bodily life is always valuable, but its values are not unchanging. "Its value must be assessed in terms of its potentiality as well as in terms of its presence." 65 Richard A. McCormick writes in contradiction to Nelson's view. He states that "if the problem is not confronted well, we will become victims of the ongoing ethic in our country—a sliding utilitarian scale which compromises the dignity of human life." 66 He warns that today's problems are a paradigm. The type of moral reasoning employed today, its precision, its sensitivity, and its combination of finality of commitment with appropriate tentativeness of formulation will affect the nature of bioethical problem solving in the years ahead. 67

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64Ibid.
65Ibid.
67Ibid., p. 76.
McCormick believes that the moral problem itself is quite simple. A basic human value is challenged by new circumstances, and these circumstances demand that imagination and creativity be employed to devise new formulations, new understandings, while keeping the basic grasp upon the value.

If the moral problem in itself is simple, as McCormick believes, then the difficulty must lie in the solution of the problem. McCormick suggests that "new understandings" and "new formulations" be devised to meet the challenge that new circumstances present to basic human values. As circumstances change, values may have to be re-evaluated and new priorities set. In this area of value "weighing," Paul F. Camenisch, associate professor of religious studies at DePaul University, Chicago, poses a different question for consideration: "Abortion: for the fetus's own sake?" He believes that in the many arguments in the abortion discussion, the only difficulty is in deciding how much weight ought to be given to the considerations that are put forward. He gives the following example:

we generally have little difficulty understanding the logic of the suggestion that the fetus be aborted for the sake of the mother (to preserve her life or health, to respect her right to determine what happens to and in her body), or for the sake of society (to slow down population growth, to cut the drain on limited medical resources). The logic of the arguments is clear. . . . the difficulty is only in assigning these considerations their appropriate weight: how should these benefits be balanced against both the possible conflict between abortion and the value of the partig involved and against the values of carrying the fetus to term? 69


69 Ibid.
Camenisch looks to the opposite possibility: arguments that are puzzling not in respect to their relative weight but rather in regard to the logic of their assertions. He cites the questions "What about the deformed fetus? Should we not abort it for its own sake?" or "What right have we to inflict upon the fetus the tragic consequences of the Tay-Sachs disease (or the Down's syndrome, the ________)?" It is in this area that the defender of abortion may find a unique weapon, according to Camenisch. He writes:

The easiest and sometimes the most telling charge that can be made by an opponent of abortion against its defender is that the latter is lacking in concern and compassion for the "victim," that the presence of this other being has been completely ignored. But with the arguments under consideration here the supporter of abortion can rightly rebut this charge and suggest that concern for the fetus can, at least in some circumstances, strengthen the case for abortion rather than undercut it. And finally it is precisely these arguments which seem to be invoked most often when abortion follows genetic counseling or amniocentesis.

Camenisch further explores what he calls the "benefits of non-existence:"

Others have noted that much of the problematic character of the choices we confront with the diagnosed malformed fetus derives from the fact that in this case we do not deal with alternative benefits to the fetus in the usual sense, but with the more basic question of the fetus's very existence. And, most perplexing of all, we are asked to consider the termination of the fetus's existence, the granting of nonexistence, as a benefit to the fetus. We are met by the argument that given the limited choices we have, it is a benefit to the fetus, a form of love toward it, to choose for it nonexistence over the only, the less than optimal, existence available to it. "Since we cannot give you perfection (or normalcy), we give you nothingness." 

Camenisch asks "can we speak of benefits without a beneficiary?" 

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70 Ibid., pp. 38-9.
71 Ibid., p. 39.
72 Ibid.
It can be seen then that questions such as What is human? and What is the value of life? are far from easy to define. Right to life requires more than a simple "yes" or "no" answer. Paul Ramsey, a Methodist layman and Harrington Spear Paine, professor of religion at Princeton University, in an article "Protecting the Unborn" asks the question of society: "How do we as a people determine the outer limits of human community?" 73 And this question leads us to the last aspect of the abortion problem to be considered in this chapter: sociological considerations.

**Sociological Aspects**

Many of the thoughts expressed in this section have already been touched upon in the legal, religious, and moral aspects of abortion. This section will briefly consider the sociological trends already alluded to in other sections.

Georgia Kinnamon Adams, lecturing at the American Nurses' Association Convention in 1974, stated:

Societal views are those generally accepted as right and fair within a particular population. Abortion has been the object of strong negative views and negative sanctions or taboos. In the United States, we have passed through an era in which contraception and abortion were both negatively sanctioned. However, as such practices gained social acceptance, there was a change in views of "what is right." . . . The process culminates when that which is accepted as common practice becomes law. The United States has recently gone through this process on the issues of abortion. . . . This change in the status of abortion has had a decided impact on what individual women consider moral. 74

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We can ask the question, "What caused this shift of public opinion with respect to this particular issue (abortion)?" The answer is "advances in scientific technology." "Scientists," according to British journalist Ritchie Calder, "leave their discoveries like foundlings on the doorstep of society." 75 Reverend Charles Carroll put it thus: ". . . we have become technological giants and moral Pigmies, thrilled by every scientific advance; intimidated by every demand for moral courage." 76

Abortion is not simply a personal problem. No man or woman is an island. We have responsibilities to ourselves and to others. Daniel Callahan agrees emphatically that abortion is not simply a personal problem; society is involved.

If society is a vital component, what sociological trends have been associated with the abortion issue? The major trends are:

1. "The Abortion Culture"

"The Abortion Culture" is the title of an article written by Nick Thimmesch, a syndicated columnist for the New York newspaper, Newsday. In his article, Thimmesch states that the "abortion culture is upon us." He questions the value of human life, ". . . a question embracing abortion . . . euthanasia . . . the creeping utilitarian ethic in medicine that impinges on human dignity." 77 He adds:

75Ritchie Calder, quoted in Robert P. Hudson, "How Real is Our Reverence for Life?," Prism (June 1975): 20.


It's all reminiscent of the "what is useful is good" philosophy of German medicine in the '30's--a utilitarianism that sent 275,000 "unworthy" Germans to death and helped bring on the Hitler slaughter of millions of human beings a few years later.

Now super-abortionists and others...cry that this is scare stuff inspired by hysterical Catholics waving picket signs. Not so. There is growing concern among Protestant and Jewish thinkers about "right to life"...Fetal life is cheap. 78

Not all have such a negative view of society. Charles J. Corcoran, O.P. of the Aquinas Institute, Dubuque, Iowa, writes:

And when...unforeseen [sic] moral questions do arise, the church...must collaborate in finding the answer through public discussion, with confidence in the conscience of society. On some issues society will form its conscience primarily in and through the professions, which are the organs of society in matters requiring great knowledge and skill. The church must share the common trust in human freedom as a self-purifying stream. The public at large may think wrong...but if given enough time it tends to think straight...Some of the greatest evils in the history of man have been done 'for the other person's own good' by a love acting out of bounds. The boundaries cannot be set by an autocratic individual nor by an elite minority. They must be arrived at by public discussion, be accepted freely by the conscience of society aided by its professions, and be open to reassessment with the increase of human knowledge and the change of human needs. 79

2. Women's Liberation

Basically, women's liberation is the right of the woman to make her own decisions, to control what happens to her body, to be equal.

Paul R. Ehrlich and John P. Holdren, writing in the Saturday Review, ask "has a potential human the right to live inside an actual woman without her consent?" They state that one reason for the acceptance of legal abortion is "...the efforts of American women to achieve

78Ibid.

status and privileges equal to those enjoyed by men." 80

In opposition, Dr. F. P. Doyle, a medical practitioner from Winnipeg, stated in a lecture given at the Medico-Moral Institute in Winnipeg that:

...Women's liberation movements appear to use abortion on demand as their rallying cry. Almost as if to glorify this act would be the symbol of complete liberation! A physiological process peculiar only to women apparently must become pathological in order to attain the professed goal!

It is indeed strange and almost beyond belief, that the most superb physiological achievement of human nature is being downgraded and aborted by its very author--woman. Should not women's liberation movements champion the positive rights of woman, rather than frustrate the very pinnacle of her triumph! 81

3. Abortion and Population Control

Diane Munday, general secretary of the Abortion Law Reform Association, writes that "it is an irrefutable fact that, on a global scale, induced abortion provides the commonest method of birth prevention." She adds:

Yet, despite this knowledge and in the face of almost universal practice, the old adage 'prevention is better than cure' is probably more self-evident and more acceptable when applied to human reproduction than to any other sphere of man's activities. Unfortunately, because the facts have for too long been unpalatable, we are now in a situation where new methods and a stepping-up of education and research programmes hold out hope for effective 'prevention' in the future, but meanwhile the problem daily grows larger and abortion seems to be the only demonstrably effective 'cure' currently available. 82

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81 F. P. Doyle, "Is There Any Justification for Abortion?," Catholic Hospital 3 (September 1972): 10.

F. P. Doyle holds the opposite opinion. He believes that the answer to the "population explosion" does not lie in abortion, but rather in control of conception and states "control of conception would appear a far more logical step to take, from anyone's point of view, than deliberate abortion." 83

4. Abortion and Economics

Some argue that the termination of pregnancies with genetic defects would reduce the costs involved in the care of such children, and ultimately, adults. Experts in eugenics and genetic counseling are interested in knowing if there is such a thing as equal health care for all. If there is, economists ask, "Can we afford it?" Robert P. Hudson, Chairman of the Department of History and Philosophy of Medicine, University of Kansas, points out that "there must exist a limit to the amount of our gross national product we can reasonably assign to the health industry. And the simple existence of such a limit places us squarely in the face of a painful choice—who will be turned away." 84

3. Social Pressures

Daniel Callahan refutes the proposition that "in a just society there would be no abortion problem, since there the social and economic pressures that drive women to abortion would not exist." 85 In refuting this he writes:

83 Doyle, Justification for Abortion, p. 10.

84 Robert P. Hudson, "How Real is Our Reverence for Life?," Prism 3 (June 1975): 21.

This proposition is usually a part of a broader political argument which sees abortion as no more than a symptom of unjust, repressive societies. To concentrate on abortion as a response to poverty, poor housing, puritanical attitudes toward illegitimacy, and racism is a cheap and evasive solution. 86

6. Legal Status of the Fetus

Commenting on the Supreme Court abortion decision of 1973, Paul Ramsey, in a stinging comment, states "to say the least, the Court started these retrogressions into technological medical barbarism... when it exercised no judicial restraint, when it refused to trust the people's moral sensibility and legislative deliberation to achieve rough agreement about who belongs with us in the community of equal-rights bearers."87 The recognition of the fetus as a legal (protectable, under the law) or non-legal (not recognized by law, therefore not protectable) entity has many sociological implications. As mentioned previously in the legal aspects of the abortion problem in this chapter, if the fetus does not have any right legally, why does society have laws regulating the drugs which may be given to a pregnant woman which could harm the growing fetus? It seems the law recognizes and does not recognize the rights and existence of the fetus.

7. Public and Professional Educational Resources

Renee C. Fox, writing in the Milbank Memorial Fund Quarterly, mentions some of the resources becoming available due to the impact of modern technologies on our lives:

... the media through which these concerns [meaning of the quality of life, dignity and degradation, et cetera] are expressed, are manifold. Articles and editorials on these topics not only

86 Ibid.
87 Ramsey, Protecting the Unborn, p. 310.
appear frequently in medical and scientific journals, but also in popular magazines and daily newspapers.

The number of books that have been published on such subjects and themes in the past ten years is impressive. Leading the list, in saliency and frequency, is a group of books on death and dying. Another important collection of books that has appeared in the last few years is devoted to the ethics and legal aspects of biomedical research on human subjects. What is perhaps more striking is the fact that the interest and work that these publications reflect have brought into being a network of new organizations whose principal raison d'être is to deal with these matters. Among the most prominent in the United States are the Institute of Society, Ethics and the Life Sciences in Hastings-on-the-Hudson, New York; the Foundation of Thanatology in New York City; the Euthanasia Society of America and the Euthanasia Educational Fund, both in New York City; the Committee on the Life Sciences and Social Policy of the National Research Council, a division of the National Academy of Sciences in Washington, D.C.; and the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics, located at Georgetown University in Washington. With the exception of the two euthanasia societies, these groups, and others like them, have all been founded since 1969.

The sociological thoughts expressed here are, by far, incomplete. But they do give a representative sample and a fair idea of the complexity and emotionality of the abortion problem.

In summary, defining abortion presents little if any problem. The implications of abortion—religious, legal, moral, sociological—are manifold and complex. The changes in the legal field alone are staggering since the landmark abortion decision by the United States Supreme Court in 1973. The questions "When does a fetus become human?" "What are the rights of the unborn?" "What are the rights of the mother?" and "What are the rights of the father?" remain highly controversial subjects in which there appears to be little agreement.

Religious thinking spans the entire spectrum of the issue—at the one pole, the Catholic position which is clearly anti-abortion, and at the other pole, the Jewish position which, in its laws, does not mention abortion as a crime. Sociological aspects, such as "the abortion culture," women's liberation, population control, and economics, all contribute to the complexity of the problem.

Abortion, though covered briefly, represents one end of the life spectrum; euthanasia the other. While different, somehow they are the same. Many ideas expressed in this chapter on abortion are relevant to that of euthanasia. Chapter three will consider euthanasia.
CHAPTER III
CRITICAL LIFE ISSUES--EUTHANASIA

In chapter two, the critical life issue analyzed was abortion. Another issue, which may also cause disequilibrium within the individual's internal or external environment, and one which is linked closely with abortion, is euthanasia. With regard to this abortion-euthanasia relationship, Professor Robert S. Morison of Cornell University writes: "the same considerations that apply to abortion would appear to apply, in principle, to decisions at the other end of the life-span." Chapter three, therefore, will define euthanasia and discuss the religious, legal, and other implications of this issue.

Definition

"Since we shoulder our responsibility for birth control, a feature of every civilized culture, can death control be far behind? If we have a right to initiate a life deliberately, may we not terminate one? Depending, of course, upon the circumstances." Joseph Fletcher, authority in medical-moral problems goes on:


There are really two questions here, one factual and one moral. . . . In actual fact the practice of death control is increasing, due to medical pressures and human needs so great that they provide their own moral justification. And as the practice is further justified by the situation, it is more easily and sensibly encouraged and disinhibited. It is exactly in this sense that I use the term right—as something justified pragmatically by the situation. 3

What then is euthanasia? Sissela Bok, lecturer in medical ethics at Radcliffe College, reports two definitions of euthanasia:

The Oxford English Dictionary (1971) defines euthanasia as "the action of inducing a quiet and easy death."

Webster's Third New International Dictionary (1967) defines it as an "act or practice of painlessly putting to death persons suffering from incurable conditions or diseases." 4

Bok also cites Lord Moynihan in an address given at the 1936 British Parliamentary Debates:

...Arguing for the introduction of a bill to remove the prohibition of voluntary euthanasia, [Lord Moynihan] held that: "briefly our desire is to obtain legal recognition for the principle that in cases of advanced and inevitable fatal disease, attended by agony which reaches, or over-steps, the boundaries of human endurance, the sufferer, after legal inquiry and after due observance of all safeguards, shall have the right to demand and be entitled to release." 5

Bok asks the questions: Must the patient necessarily be suffering? Must the patient be close to dying? Must the patient have requested help in dying? "And is euthanasia an act of putting the patient to death, or can it also describe suicide and omission or cessation of care?"6

3Ibid.


5Ibid.

6Ibid.
Many have tried to answer these questions. Some have used the literal translation of euthanasia: "good death." The common term used by the lay public is "mercy killing." Curtin notes that more recently theologians have made further distinctions. Euthanasia may be positive, negative, direct, indirect, active, passive, voluntary, involuntary, and even compulsory. Curtin quotes Professor Williams of the University of Washington School of Medicine, who writes it is now "institution of therapy that is hoped would hasten death." 

Curtin offers the following distinctions:

**Active, Direct, Positive:** The use of these terms in connection with euthanasia denotes that direct action is taken to terminate the patient's life. The implication is that of mercy killing.

**Negative, Passive, Indirect:** Implies that no extra-ordinary means were used to prolong the patient's life. . .ordinary means are employed.

**Voluntary, Involuntary, Compulsory:** Refers to the degree of knowledge and consent on the part of the patient.

Fletcher more clearly defines these distinctions. In the management of terminal illness, he states, there are two distinct moral problems which are closely related but are not the same. One is euthanasia and the other, "by far the more pressing in its frequency," according to Fletcher, is "letting the patient go" or as Fletcher calls it, antidysthanasia. According to him, the classic debate is about mercy killing: doing something directly to end a life easily, or of not doing something or omitting to do something so that death will come

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8Ibid., pp. 6-7.

easily. To clarify these distinctions, Fletcher offers the following definitions and examples of euthanasia:

"1. Direct voluntary, as when a patient consciously chooses to end it all, with or without medical intervention. Such is the case of the patient who sneaks an overdose or has left one within reach, or who swallows Kleenex or pulls out a tube. It is deliberately done and consciously willed by the patient.

"2. Indirect voluntary, as when a patient before reaching an unconscious or comatose state (while still competent and with a mens sana even if not in corpore sano) gives leave to his medical servants to use discretion about letting death come. This, too, the patient has willed, yet his death is not directly done but indirectly by ceasing opposition to it. Such is the case of those who, after consultation, "pull the plug" at some point of diminishing returns.

"3. Indirect involuntary, as when a patient’s wishes are not known and yet doctors and/or his family and friends choose for him to stop fighting off death. Such is the case when the pain, subhuman condition, irreversibility, cost, injustice to others, and the like, combine to outweigh the benefits of keeping him alive. This third form is far and away the most typical and frequent situation—indirect euthanasia, without the patient’s past or present opinion in the account, except as it might be presumed.

"4. Direct involuntary, as when a patient’s wishes are not known, yet in the judgment of physicians, family, or friends it seems better to them to end his life by a "mercy killing" than to let it go on, as it will. Such a case would be a decerebrated person, perhaps one whose cerebral cortex has been shattered in an auto accident, in "excellent health" biophysically, fed by indwelling nasal tubes, unable to move a muscle, suffers no pain but only reacts by reflex to a needle prick. I know one such, a young man (who now looks like a child), and his mother says, "My son is dead." Another case would be an obstetrician’s decision not to resuscitate a monster at birth, or a "blue baby" deoxygenated beyond tolerable limits of cyanosis or brain suffication. . .

. . .Whether euthanasia is direct or indirect, voluntary or involuntary, is ethically something that depends upon the facts in the situation, not upon some intrinsic principle regardless of realities." 10

10Ibid., pp. 147-48.
Considering the above definitions and assertions, two points must be kept in mind. First, A. V. Campbell cautions that the spheres of law and morality must be distinguished. At present, as the law stands, direct destruction of the life of a patient, whether or not he has requested it, is murder; and failure to institute life-saving measures might, depending upon the circumstances, constitute culpable negligence. Euthanasia legislation would remove certain instances of direct killing of patients from the category of murder and failure to carry out treatment would presumably continue to be assessed according to circumstances.11

Secondly, it can be pointed out that a patient who performs "direct voluntary euthanasia," according to Fletcher's definition, is in actuality committing suicide. Euthanasia, on the other hand, usually involves the action of someone else other than the patient.

These distinctions between active and passive euthanasia become crucial for the members of the health field. That it is permissible, in some cases, to withhold treatment and allow a patient to die, but that it is never permissible to take any direct action designed to kill the patient, is a doctrine that is accepted by a majority of physicians and nurses. It was endorsed by the American Medical Association on December 4, 1973, and cited by James Rachels, Department of Philosophy, University of Miami:

The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family. 12

Rachels develops an argument against this doctrine. Physicians believe that there is an important difference between active and passive euthanasia. In passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient dies of his condition. In active euthanasia, the doctor does do something to bring about the patient's death. Rachels' point in this argument: it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. 13

With these standard definitions of euthanasia in mind, other words and phrases used in discussing this issue which need defining are "ordinary" means and "extraordinary" means, "prolongation of life," and "quality of life." Father Richard A. McCormick, professor of Human Ethics at the Kennedy Center for Bioethics at Georgetown University states that the definition of what is "ordinary" and what is "extraordinary" is relative. What is beneficial to the patient and what is excessively difficult are notions relative to time, locale, the condition of the patient, the competence of the medical assistance available, and many other factors. He further points out that the terms "ordinary" and "extraordinary" are but code names. They


13Ibid., p. 80.
summarize and are vehicles for other judgments but they do not solve problems automatically. They are emotional and mental preparations for very personal and circumstantial judgments that must take into account the patient's attitudes and value perspectives or "what the patient would have wanted."

Schoewalter, Ferhot, and Mann, who are more specific than McCormick, define extraordinary means of preserving life as: "...all medicines, treatments and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others or which if used, would not offer reasonable hope of benefit to the patient."

A. V. Campbell approaches the definition of ordinary and extraordinary means using natural law. He states that the preservation of life has been regarded as a fundamental principle of natural law and thus to deliberately cause the death of another or commit suicide would be violations of natural law. He proceeds to ask the question: "Does it then follow that a patient is under an obligation to take all means available for the preservation of his life, in order to avoid committing suicide?; and is a doctor under an obligation to employ all such means if they are at his disposal, in order to avoid committing murder?" He adds:

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14McCormick, "Quality of Life," p. 77.


16Campbell, Moral Dilemmas, p. 98.
The concept of "extra-ordinary means" relieves doctors and patients of such obligations, arising from the principle of the sanctity of life, by arguing that there is no absolute obligation to employ any means which will cause an intolerable burden to the patient or his relatives. . . . What constitutes an 'intolerable burden' depends on the circumstances of the patient, the degree of development of the particular medication or surgical procedure and the cost and availability of the treatment proposed. Thus penicillin might have been regarded as an extra-ordinary means at one time because of cost and uncertainty of its effect, but now it is clearly an ordinary means of combating infection. Haemodialysis and organ transplantation appear to fall into the extra-ordinary category at present . . . but in the future they may become routine . . .

It will be observed that this principle provides only a rough and ready guide for the application of the obligation to preserve life . . .

. . . The distinction between ordinary and extra-ordinary means ceases to be helpful when really difficult decisions about the quality of life have to be taken. 17

Gerald Kelly, S.J., of St. Mary's College, approaches ordinary and extraordinary means from the position of the moralists. He states that although the moralists do not always define these terms, a careful examination of their words and examples reveals substantial agreement on the concepts. He states: "by ordinary they mean such things as can be obtained and used without great difficulty. By extraordinary they mean everything which involves excessive difficulty by reason of physical pain, repugnance, expense, and so forth."18 Putting it succinctly, an extraordinary means, according to Kelly, is one which prudent men would consider at least morally impossible with reference to the duty of preserving one's life.

17 Ibid., pp. 98-108.

Kelly also looks to the individual's duty, and writes that the following are commonly accepted principles:

*Per se* he is obliged to use the ordinary means of preserving his life. *Per se* he is not obliged to use extraordinary means, though the use of such means is permissible and generally commendable. *Per accidens*, however, he is obliged to use even extraordinary means, if the preservation of his life is required for some greater good such as his own spiritual welfare or the common good. 19

So much for ordinary and extraordinary means. The other phrases "prolongation of life" and "quality of life" go hand-in-hand. One can hardly talk of the prolongation of life before one is immediately challenged by the statement "but what of the quality of this life?"

This question was asked in abortion, it is asked in euthanasia. Rev. Charles Carroll, Protestant chaplain, University of California, San Francisco Medical Center, in an address before the XII International Congress of Catholic Physicians in 1970, stated: "to discuss the prolongation of life without also discussing the abbreviation of life, represented by abortion on demand, is to ignore the total problem—that of life control and death control." 20

McCormick says of "quality of life:"

... an elusive term whose meaning varies according to context. ...
... at a profound level, when the issue is preserving human life, the term assumes a more basic meaning. Just as life itself is a condition for any other value or achievement, so certain characteristics of life are the conditions for the achievement of other values. We must distinguish between two sets of conditions: those that allow us to do things well, easily, comfortably, and efficiently, and those that allow us to do them at all. Life/death

19 Ibid., p. 206.

20 Charles Carroll, "The Human Person: Experimental Laboratory or Privileged Sanctuary?", Hospital Progress 52 (June 1971): 35.
decisions in contemporary medicine involve quality as it pertains to the second set of conditions. 21

Fletcher writes: "to prolong life uselessly, while the personal qualities of freedom, knowledge, self-possession and control, and responsibility are sacrificed is to attack the moral status of a person. It actually denies morality in order to submit to fatality." 22

Leah Curtin, in her treatment of "quality of life" which she calls "meaningful life," states that there are two basic value questions that must be answered: What is life? and What is meaningful life? She answers: "The former is relatively easy to answer. Life is a state of being in existence. The real difficulty comes in trying to define the latter." 23 Fletcher does not appear to have difficulty in defining what is necessary in order for a human to have a "meaningful life." Fletcher employs "indicators of humanhood." He offers the following as "Positive Human Criterion:"

"1. Minimal intelligence (I.Q. of 40 questionably a person, below 20, not a person).
"2. Self-awareness.
"3. Self-control.
"4. A sense of time.
"5. A sense of futurity.
"6. A sense of past.
"7. The capability to relate to others.
"8. Concern for others.
"10. Control of existence.
"11. Curiosity.
"12. Change and changeability.

21McCormick, "Quality of Life," pp. 77-78.
23Curtin, Mask of Euthanasia, p. 8.
"15. Neo-cortical function." 24

Robert L. Sinsheimer, in an essay treating the prospects for future scientific developments, offers the following characteristics of humanity:

"1. Our self-awareness.
"2. Our perception of past, present, and future.
"3. Our capacities for hope, faith, charity and love.
"4. Our enlarged ability to communicate and thereby to create a collective consciousness.
"5. Our ability to achieve a rational understanding of Nature.
"6. Our drive to reduce the role of Fate in human affairs.
"7. Our vision of man as unfinished." 25

Sinsheimer's characteristics almost parallel those of Fletcher but he offers one other interesting observation:

An ancient and valuable question has been—What does it mean to be human? I believe the answer to that has changed as we have added our growing cultural inheritance to our biological inheritance. If these now interact, the answer will change still more. And that is in itself an important part of the answer which can only be—in a Delphic fashion—that to be human is simply to partake in an endless experiment to resolve that very question. 26

Curtin quotes John Lachs, from an article which appeared in the New England Journal of Medicine, and states:

... In this article, Dr. Lachs suggests that our senses are in error in regard to persons with hydrocephaly and lead us to the erroneous conception that such beings are human. Due to this misconception, we tend to treat hydrocephalics as if they were human

26Ibid., p. 349.
when "the only way to treat such beings is not to treat them as humans." He claims that they are merely "organisms in human shape," that "pigeons have more personality. . .than this unfortunate moon-calf in our midst" and that "they must mercifully be put to death." 27

In rebuttal to these attempts to set criteria for humanhood, Curtin writes that "attempts to set 'criterion for humanhood' are regrettable . . .if they are to be used to determine who among us is human and who is non-human," and further:

We speak of "standards of humanhood" as if we were addressing ourselves to defective machines! By denying humanity to others, by refusing to care, by abrogating our responsibilities towards others, we are not dehumanizing them, we haven't the power to do so—we are dehumanizing ourselves. In his book, Ideals of Life, Millard Everett writes that "no child be admitted into the society of the living who would be certain to suffer any social handicap—for example any physical or mental defect that would prevent marriage or would make others tolerate his company only from a sense of mercy." If such a thing should ever come to pass, then the process of the dehumanization of man would be complete! 28

It can be seen that there are diverse opinions as to what is meant by "quality of life." At the one pole, it is those who hold to the criterion offered by Fletcher and Sinsheimer; at the other pole, the proponents of life above all, regardless of quality. Somewhere in between these two poles are those who advocate letting people "die with dignity."

With the basic definition of terms completed, the legal, religious and other implications of the issue can be considered.

28 Ibid.
Legal Aspects

The legal aspects involved in the abortion issue are relatively simple since the Supreme Court decision of 1973 when compared to the legal aspects which must be considered with euthanasia. There has not been a Supreme Court decision on euthanasia in any form, but many attempts by the states have been made to legalize some forms of euthanasia. In September, 1976, one of the attempts was successful: California passed the nation's first "right-to-die" law.

Linking abortion with euthanasia, Reverend Kevin D. O'Rourke, director of the Department of Medical-Moral Affairs, The Catholic Hospital Association of St. Louis, writes of the Supreme Court abortion decision:

The Supreme Court, in its abortion decision, has so weakened and cheapened the value of human life, has so befuddled the notion of the state's responsibility to foster humane and ethical relationships in society, that efforts to pass laws requiring passive euthanasia will increase in the immediate future. If the unborn human being has no right to life, why then spend any time prolonging the life of a person who might die anyway? (Underscore mine.)

It can be seen that, just as in abortion, the emotional aspects of this issue are highly charged. Baughman, Bruha, and Gould, writing in the Notre Dame Lawyer, conclude:

29 Two examples of proposed legislation are 1) H.R. 2655--Bill introduced to the 93rd Congress in January of 1973 to establish a Commission on Medical Technology and Dignity of Dying; and 2) Proposed legislation for 1972 session of the Florida Legislature by Representative Walter W. Sackett, Jr., M.D., providing for termination of sustaining treatment of terminally ill or injured patients in certain circumstances and providing immunity for physicians.

There is a necessity for replacing our neurotic attitudes toward death and viewing death as a biological function. It is only in that context that the merits of euthanasia legislation can be clearly and objectively perceived. 31 Baughman, Bruha, and Gould in their survey give a clear and succinct review of what the criminal, tort, constitutional and legislative considerations are in the euthanasia issue. They point out that the stirrings of legislative thinking in euthanasia crystallized in the formation of the English Euthanasia Society in 1932. The Society proposed a voluntary euthanasia act in both 1936 and 1937. Despite support from the Church of England, among others, the act was defeated.

Despite its defeat, the act has become the prototype for subsequent legislation in England and the United States. The important concept brought out by this act was that death by euthanasia should not be deemed an unnatural death. Implicit in the concept is the view of life from a qualitative perspective rather than in absolute terms of mere existence. This English act was restricted to consensual euthanasia by competent adults. The patient would execute a certificate of intent stating his desire for an advanced death if he should suffer from a terminal illness.32 This act was a powerful influence on American legislation.

The American Euthanasia Society was formed in 1938 by the Reverend Charles Francis Potter. In 1972 the Society changed its name to the Euthanasia Educational Council. The American proposal was similar to the English one except for its provision for involuntary euthanasia


32 Ibid., p. 1252.
of monstrosities and imbeciles. Baughman and associates write that this proposal was too startling for a child-centered society with an "almost defined folklore speaking of its protection of the helpless."\(^{33}\)

The first euthanasia bills to be introduced in the United States were in Nebraska and New York. Neither bill was enacted.

For a period of time euthanasia legislative activity was dormant in both the United States and England, then it became active when the House of Lords made another legislative attempt with the Voluntary Euthanasia Act of 1969. This bill, just as the ones introduced in the 1930's, was not enacted either. The bill limited the discretion of the physician to a termination of steps to prolong life. The act did require an advance declaration of intent—a certificate of intent. A counterpart to this certificate of intent today is the "living will" proposed by Luis Kutner and as prepared by the Euthanasia Educational Council (Appendix A). John F. Monagle, while agreeing ethically with the "living will" opposes it legally for the following reasons:

(1) If the patient is living but unable to communicate, he/she cannot change his/her mind, (2) the name "Living Will" is a legal contradiction in that it is executed prior to death, (3) the legal difficulties in defining "no reasonable expectation of recovery" and (4) an increase in malpractice suits against doctors who "try too hard" when they misinterpret "reasonable expectation of recovery," and (5) the difficulty in legally defining the term "heroic measures."\(^{34}\)

The Honorable Judge Michael T. Sullivan, of the County Probate Court, Milwaukee County, agrees with Monagle's conclusions and states that the living will may cause more problems that it solves. He asks:

\(^{33}\)Ibid., p. 1253.

...can any reasonable minds concur, in a given case, upon such tenuous concepts as (i) "if the time comes when I can no longer take part in decisions. . . ." (ii) "no reasonable expectation of recovery. . . ." (iii) "kept alive by artificial means. . . ." (iv) "drugs be mercifully administered. . . ." 35

Reverend K. O'Rourke asks the questions "what if the stipulations of the 'living will' were mandatory by law? What would result?" 36 He states that one possibility would be the effect on the patient-physician relationship: that physicians might refuse to use any extraordinary means for fear that someone could later sue them for malpractice. O'Rourke quotes Elisabeth Kubler-Ross, the psychiatrist and noted expert on death and dying: "I am afraid to legalize (passive euthanasia) bills like this because I am afraid of the loopholes which would make it possible 'to eliminate' people's lives when they become too costly or too much a burden to us." 37

Another criticism of the living will has been directed to the idea that a person's intent may change over the years. The problem would be acute in such cases where the patient is now mentally incompetent and yet insists upon revoking his declaration. Edward J. Gurney, U. S. Senator from Florida, and member of the Special Committee on Aging of the U. S. Senate, writes that "one of the problems with such a declaration is developing a satisfactory procedure for revocation." 38

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36O'Rourke, "The Right of Privacy," p. 60.

37Ibid.

From these historical beginnings of legislation, certificates of intent and "living wills," Baughman and associates note a constitutional dilemma:

By present state law standards, euthanasia constitutes an intentional taking of life, without provocation... in other words, murder. The administration of those standards, however, exhibits the attitude that euthanasia is less reprehensible than other forms of homicide. Perpetrators, therefore, usually escape the burden of a murder conviction. This dichotomy between theory and practice creates a constitutional dilemma. By failing to treat the perpetrators as murderers, the state may be denying the victim of euthanasia both due process and equal protection of law. By convicting euthanasia perpetrators as murderers, however, the state may be exacting an excessively cruel and unusual punishment.

State law purports to protect terminal patients from having their lives prematurely terminated. State law as applied, however, does not deal with euthanasia perpetrators as murderers... More often, the state never calls upon these individuals to answer for their actions. The state, therefore, has in effect weakened and perhaps removed the safeguard that homicide laws once provided for the life of the dying patient. Baughman and associates conclude that the present state law approach, both in theory and application, fails to provide adequate safeguards for the constitutional rights of euthanasia perpetrators and their victims.

Another aspect of this dilemma is: Is there a constitutional right to die? Baughman and others write that the terminally ill or incurable patient may have some constitutional protection from state interference. The right of privacy, derived from the ninth and fourteenth amendments, has "received consideration as a possible safeguard against state-imposed measures to prolong life for those near death who wish to die prematurely." They add: "Recent cases utilizing the

40Ibid., p. 1237.
right to privacy to uphold personal liberties seem to indicate the recognition of a right to control one's own body,\(^{41}\) and further:

The common law acknowledges this prerogative, protecting the individual from undergoing medical treatment to which he has not consented, except in emergency situations where the patient is unable to give consent. \(^{42}\)

Does anything or can anything override the right to control one's body?

Baughman and others state:

There do exist, and courts have recognized, certain compelling interests overriding the right to control one's own body. These interests may not appear so substantial, however, when examined in light of those suffering from terminal or incurable disease desiring premature death. American society strongly affirms the sanctity of human life and, therefore, no fundamental right could probably stay the hand of the state from prohibiting terminal patients from employing active measures to prematurely terminate life. Such persons may, however, enjoy the right to refuse both ordinary and extraordinary treatments designed to prolong existence. \(^{43}\)

Baughman concludes that the Supreme Court has recognized the right to privacy as fundamental and that recent case law seems to indicate that this guarantee may afford to dying patients a limited right to die. That although in some cases compelling state interests may override such a right, many terminal patients should be able to enjoy the prerogative to refuse ordinary and extraordinary treatment free of state interference.

Leaving constitutional law and considering euthanasia and criminal law, Baughman, Bruha, and Gould write that there is little case law on the euthanasia subject per se. They point out that prosecutions for

\(^{41}\)Ibid., p. 1239.

\(^{42}\)Ibid.

\(^{43}\)Ibid., p. 1242.
euthanasia are rare, and if brought to prosecution are seldom convicted. They add:

...this does not mean, however, that the law regarding euthanasia is nebulous or embryonic. Despite the paucity of written decisions, the common law attitude towards euthanasia is clear—it is theoretically murder in the first degree. 44

Under common law, every civilized legal system considers euthanasia a crime. The seriousness of the crime differs however. For some, it is manslaughter (German and Swiss); for others a special form of homicide (Poland); for yet others, an offense punishable by fine, if punished at all (Uruguay). In Anglo-American common law it is a serious offense. The law is not only applied to the perpetrator but also is imposed on any one who aids another in the commission of euthanasia. The accomplice is as guilty as the person who actually commits the offense, and is subject to similar punishment.

Under criminal law, Baughman and associates consider the following:

"A. Aiding and Abetting Suicide:

A criminal offense in most American jurisdictions. Some states consider it murder, others manslaughter or as an entirely different offense.

"B. Euthanasia by Omission:

Where life is terminated by a positive act criminal liability is clear; but euthanasia by omission (sometimes called antidysthanasia) remains one of the unsettled areas of the law. The law imposes criminal liability for an omission to act only where there is a legal duty to do so; therefore if there is no duty, there is no liability. 45

44Ibid., p. 1203.

45For a more detailed analysis of the physician-patient relationship and duty, the reader is referred to pp. 1207-1210 of the Baughman article.
"C. Time and Definition of Death:

Legal death has traditionally been defined as the cessation of life. . .defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc. It has been pointed out, however, that such a definition is impractical in light of modern artificial means of continuing heartbeat and respiration almost indefinitely.

The Journal of the American Medical Association, in a 1968 article 'A Definition of Irreversible Coma' offers the following: From ancient times on to the recent past it was clear that when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heartbeat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now restore 'life' as judged by the ancient standards of persistent respiration and continuing heartbeat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage.

For the purposes of the statute, death occurs when there is an absence of spontaneous respiratory and cardiac function, and attempts at resuscitation are considered hopeless; or, when there is an absence of spontaneous brain function and it appears that further supportive maintenance will be useless.

"D. The Law in Practice:

Despite the evidence that euthanasia is widely practiced, at least by omission, and the broad liability imposed by the common law, there have been few prosecutions for mercy killing in this country. Hindsight has shown that even where prosecution is undertaken, juries are reluctant to convict or judges are reluctant to impose harsh sentences.
"E. Alternatives:

The common law has often been criticized for the disparity between the law in theory and the law in practice regarding euthanasia. Several alternatives have been suggested to make the law on the books more consistent with the law in the courtroom, and these proposals generally take one of two approaches—either legalizing euthanasia for the victim, or mitigating the penalty for the actor." 46

Baughman and associates continue:

The first approach has generally taken the form of legislation which would give a terminal patient the right to request euthanasia, and grant immunity to doctors acting in accordance with the statute. The second approach—mitigating the penalty for the actor—involves several different proposals. The most common of these is that the common law should expressly recognize motive as a mitigating factor, at least where euthanasia is concerned. This would have the effect of making euthanasia a lesser offense than murder. A second proposal calls on the common law to adopt several characteristics of the European codes—motive as a mitigating factor, homicide by request, etc.

To date, such proposals have met with little success, 47 and those who would favor more lenient treatment of euthanasia are turning towards constitutional law as a more rapid vehicle of change. 43

Baughman and associates conclude their entire survey of euthanasia law by stating that there is a need for legislation to clear up the confusion which exists over the "discretion that an individual has over his life." They disagree with the suggestion of Glanville Williams that there is no need for legislation. They accuse Williams


47 This was true when this article was written in 1968, but the "Right-to-Die" legislation passed in California in September 1976 appears to indicate a trend in the opposite direction. No constitutional move seems to be underway.

of being "myopic."  

Susan R. Gortner, in an address given at the American Nurses' Association Convention in 1974, discussed some possible alternatives to legislation. She stated "It is difficult to translate issues in a public policy, as through legislation before public discussion has taken place." She refers to the recommendations made by the AMA Judicial Council on the Physician and the Dying Patient which includes such areas as "greater professional discussion of physician-patients rights and duties in terminal care, greater initiative by physicians to discuss death and terminal illness with patients, greater respect for patient's expressions of wishes" and the cessation of the employment of extraordinary means to prolong life.

Legislative action can have a profound effect from a sociological standpoint. O'Rourke writes that the number of anti-life actions that might be considered constitutional are frightening. He states that "although all these actions may not be legalized by the Supreme Court, the principles developed in the right to privacy decisions do make such developments possible." He adds "compulsory abortion, legalized suicide, and euthanasia are not beyond the realm of possibility. Small changes in outlook can lead to vast changes in

49 Ibid., p. 1259.


51 Ibid., p. 175.
practice."52 Additionally, O'Rourke cites Lee Alexander, M.D., Chief Counsel of the Nuremberg war trials, who stated:

...whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted...but it is important to realize that the infinitely small wedged in lever from which this entire trend of mind received its impetus was the attitude toward the unrehabilitable sick. 53

O'Rourke thinks that the Supreme Court decides what it thinks the people want and then finds reasons to support its decisions. Therefore, public opinion is a powerful determinant of the course of legislation.

Catholic theologian, Daniel C. Maguire, writes that shifts are occurring in public thought, and that these shifts "reflect a recognition that we have overestimated our right to kill in a military setting, and underestimated it in some medical and private settings."54 And further "that any decision to end life in any context, for self or for another, must be slow, deliberate, and reverential."55

J. Russell Elkinton, Professor of Medicine, and editor of Annals of Internal Medicine, in a symposium sponsored by the Villanova Law Review, posed a most thought-provoking question, and one which is the base of this legal discussion:

52O'Rourke, "The Right to Privacy," p. 62.
53Ibid.
55Ibid., p. 85.
When Adam and Eve ate of the fruit of the Tree of Knowledge, they lost their immortality. Do we really want it back? Perhaps we have lost our perspective on death as a natural part of life. . . . 56

I have now concluded this brief account of the current legislative activities and attitudes concerning euthanasia. Religious aspects will now be considered.

Religious Aspects

In chapter two, it was concluded that organized religion is far from agreement on the abortion issue. At one end of the spectrum, the Catholic Church is absolutely against abortion in any form; at the other end of the spectrum the Jewish position, in its laws, makes no mention of abortion as a crime. The Protestant position lies somewhere, undefined, on the spectrum.

With euthanasia, there seems to be more agreement among organized religion than was found in abortion. The one area of euthanasia which seems to parallel the religious consensus concerning abortion is the area of suicide. Some religions are absolutely opposed to it, and may even deny all suicides a religious burial. On the opposite side, many religions allow it without any censure whatsoever, and may even encourage it ceremonially. Fletcher points out that, historically, suicide was encouraged by the ancient Aztec and Inca cultures, and more recently by the Hindu practice of suttee (the widow throws herself onto the funeral pyre of her husband), and the practice of hara-kiri (done after losing face or prestige) in the Japanese, Buddhist, and Shinto beliefs. The divided opinion on suicide, and therefore about

euthanasia, according to Fletcher, was also common to the Greeks and Romans. Fletcher writes:

...Pythagoras, Plato, and Aristotle held that suicide was a crime against the community. ...Plato added that it was a like crime against God. But all of these were willing to justify suicide in cases calling for a merciful death. Stoics usually, but not always, approved of suicide. Cicero, for example, condemned it, whereas Seneca praised it. Epictetus sided with Seneca. But they all favored euthanasia. 57

Judaism and Mohammedanism are opposed to suicide. Fletcher feels that opposition from these religions is due to Oriental and Hellenic influences on their doctrines; and, thus their followers tend to regard physiological life as sacrosanct and untouchable. Fletcher does stress the fact though, that neither the Bible nor the Koran explicitly condemn suicide. Of the Christians, Fletcher says:

The early Christians, like Chrysostom, followed the rabbis for the most part. ...allowed for suicide in certain forms...to achieve martyrdom, to avoid apostasy, or to retain the crown of virginity. Thus Lactantius declared that it is wicked to bring death upon oneself voluntarily, unless one was "expecting all torture and death" at the hands of the pagan prosecutors. 58

Being a strong defender of euthanasia, Fletcher adds to the above statement: "Unfortunately for the precedent moralists he never bothered to apply his logic about torture and death to incurable illness." 59

Once the Christians became a part of the Roman government, the permitting of suicide, even for defense of chastity, no longer was accepted. Fletcher writes of this period "St. Augustine swept away

57 Fletcher, Morals and Medicine, pp. 176-77.
58 Ibid., p. 178.
59 Ibid.
even that exception by announcing that chastity, after all, is a virtue of the soul rather than of the body, so that physical violation did not touch it."\(^{60}\) He adds:

\[\ldots \text{[St. Augustine]}\text{ said with fine simplicity that the scripture nowhere authorized (Fletcher's emphasis) us to eliminate ourselves. This became the conventional Christian position. ... We find that Christian burial was denied to suicides as early as A.D. 563. The Roman Church to this day, by canonical prohibition, refuses to bury a suicide.}\]

Unlike Judaism and Catholicism, Protestantism does not unanimously outlaw suicide, although various bodies will from time to time condemn euthanasia, or call it into question. As recently as 1951 the General Assembly of the Presbyterian Church in the U.S.A. resolved that suicide is contrary to the Sixth Commandment. \(^{61}\)

Interestingly enough, and paralleling the discussion of public opinion and the law, history points out that occasionally, but almost always outside the Roman jurisdiction according to Fletcher, there were testimonies to a new attitude. He points out that Thomas More, whose Utopia included euthanasia, was reflecting a new evaluation of human worth and integrity. Also, that Lord Francis Bacon in this New Atlantis expounded the view of euthanasia. That this new attitude was also reflected by the religious is seen in such a book as Biathanatos by John Donne, Anglican priest, poet, and Dean of St. Paul's, who wrote:

"Declaration of that paradoxe, or thesis, that Self-homicide is not so naturally a sin, that it may never be otherwise."\(^{62}\)

The historical considerations of suicide can, to some degree, be applied to euthanasia, since suicide is a form of euthanasia. A major difference between suicide and other forms of euthanasia is a numerical one. In suicide, only one person is involved—the patient or person

\(^{60}\text{Ibid.}\)

\(^{61}\text{Ibid., p. 179.}\)

\(^{62}\text{Ibid.}\)
himself; in all other forms of euthanasia, the help of others is necessary. For this reason, the present discussion is limited to euthanasia exclusive of anything pertaining to suicide. Suicide was brought into the discussion only to supply an historical setting.

Moving from this historical setting and into contemporary religious thinking, Dedek offers:

Our contemporary reluctance to enter into the business of terminating human lives is shaped by two factors. One is the undeniable increase in modern times of a moral sensitivity to the value of human life and the inviolability of the unique human person. It is an appropriation by our modern culture, for a variety of reasons, of values that are at the heart of the message of Jesus.

The other factor is the lingering shock and revulsion of what occurred in relatively recent Western history in Nazi Germany. The "Law for the Prevention of Hereditarily Diseased Posterity," promulgated in July, 1933, and Hitler's euthanasia decree, signed on September 1, 1939, led to the "merciful" gassing of mentally afflicted adults and deformed and idiotic children. . . . Obviously, the humane termination of the life of a man who is painfully and incurably ill and asks for a painless release from the excruciating process of dying is quite different from compulsory euthanasia or genocide. Even so, the horror produced by Dachau and Buchenwald has inclined contemporary men to distrust ever turning over to other men the right and power to decide who shall live and who shall die. 63

Judge Michael T. Sullivan, County Probate Judge for Milwaukee County, expresses the contemporary views of religious freedom and the balancing of rights. He writes that the constitutional right to religious freedom involves two elements: belief and practice. He explains "the right of belief cannot be trammeled by the state in any way; the right to religious practice involves a balancing between state interest and the individual's rights."64

63Dedek, Human Life, pp. 121-22.
64Sullivan, "The Dying Person," pp. 205-06.
In apparent direct opposition to Sullivan's position, is that of Arval Morris, who is quoted by Baughman and associates:

Arval Morris cogently observes that the failure of legislative enactments is a result of a confusion of social and medical considerations with religion. Religious grounds, he argues, are constitutionally irrelevant and a legislator shirks his duty in permitting religious considerations to defeat permissible legislation. 65

It is difficult, if not impossible, to separate the religious, legal, and sociological aspects of the euthanasia problem into hard and fast categories—this is black, this is white. There is a great deal of overlapping—a vast grey area. If public opinion and attitudes are expressed in the law, how does religious opinion get separated from non-religious opinion in an individual?

With these generalizations concerning religion and euthanasia in mind, current positions by the various major religious denominations can now be brought forth.

In response to the question "When does death occur?" proposed at the International Congress of Anesthesiologists in Rome, in November, 1957, Pope Pius XII stated:

Human life continues for as long as its vital functions, distinguished from the simple life (biologic) of the organs, manifest themselves spontaneously without the help of artificial processes. ... The task of determining the exact instant of death is that of the physician. 66

In his statement "The Prolongation of Life" Pius XII states the Catholic position:


Natural reason and Christian morals say that man (and whoever is entrusted with the task of taking care of his fellow man) has the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health. This duty that one has toward himself, toward God, toward the human community, and in most cases toward certain determined persons, derives from well ordered charity, from submission to the Creator, from social justice and even from strict justice, as well as from devotion toward one's family.

But normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities, are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.

The right and duties of the family depend in general upon the presumed will of the unconscious patient if he is of age and "sui juris." Where the proper and independent duty of the family is concerned, they are usually bound only to the use of ordinary means.

Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply. There is not involved here a case of direct disposal of the life of the patient, nor of euthanasia in any way: this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life, and one must apply in this case the principle of double effect and of "voluntarium in causa." 67

Fletcher links the opinion of the Catholic Church and the Church of England with the following comment:

. . .Pope Pius XII. . .said that in deciding whether to use reanimation techniques, if life is ebbing hopelessly, doctors may cease and desist, "to permit the patient, already virtually dead, to pass on in peace." This decision could be made by the family and the doctor for the patient. In this same vein, an Archbishop of Canterbury (Cosmo, Lord Lang) agreed that "causes arise in which some means of shortening life may be justified." Both of these

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church leaders of the recent past preferred to leave the decision as to when in the physician's hands. 68

The position of the Catholic Church can easily be summarized: the direct ending of a life is never allowed. Extraordinary and heroic measures need not be used to prolong life. The distinction between ordinary and extraordinary care has been recognized by both Protestant and Catholic writers. 69 Fletcher states that Catholic, Protestant, Jewish, and humanist teachings all have a place for euthanasia in one form or another. He also states that Catholic moralists, and most orthodox Jews and most orthodox Protestants, are opposed to euthanasia which is direct whether voluntary or involuntary—they rule out as immoral any direct methods of ending a life in order to end suffering and waste. But they allow indirect euthanasia, both voluntary and involuntary. 70

William J. Boone, Chaplain at the Mountainside and Community Hospitals, Montclair, New Jersey, has stated that there is no Protestant position as such on any of the multi-faceted ethical and religious-medical questions which modern medicine raises. He adds "rather there are manifold Protestant positions which reflect the diversity of Protestantism itself." 71 He sums up the Protestant position thusly:


69 Gurney, "Is There a Right to Die?," p. 248.

70 Fletcher; "Elective Death," p. 149.

Protestantism does not view the prolongation of life as an ethical good. Quality rather than quantity of living is the focus of ethics and the Christian life. Few would, therefore, object to restricting keeping people alive via extraordinary means. Moreover, many Protestants would argue that to prolong life artificially is fundamentally immoral because it denies a person of his ethical right to die. And still others would advocate voluntary euthanasia under certain circumstances and with a medical-lay panel evaluating and judging such a patient's request.  

Dedek sums up the general theological, medical and legal positions:

...one need not, in fact ought not use extraordinary means to prolong the life of patients who are terminally ill. Prolonging the process of dying through artificial means provides no important benefit and is generally useless and unreasonable. There is, in other words, a human right to die. There is not the same support for directly interfering to hasten death. The distinction between killing and allowing to die is theoretically defensible, and the point between passively withholding artificial means and actively giving lethal agents is a practical and reasonable place to draw a line.  

Lastly, in the Cumberland-Samford Law Review, Gurney writes that out of the religious arguments condemning euthanasia, three principles have emerged as being important. First is the principle of the sanctity of life, that no man has the right to take an innocent life. The second principle is that man does not have absolute control over his life but holds it in trust for God. The third and last principle maintains that physical suffering is not an absolute evil. While it is permissible to relieve suffering, suffering can be an occasion for spiritual growth.  

72Ibid., p. 637.  
73Dedek, Human Life, pp. 139-41.  
74Gurney, "Is There a Right to Die?," pp. 258-59.
With the religious and legal aspects as background, some general considerations about euthanasia are in order.

**Sociological and General Aspects**

Joseph Fletcher, the leading proponent of euthanasia, offers the "ten most common and most important objections to euthanasia," some of which have already been previously mentioned:

"1. . . euthanasia, when voluntary, is really suicide.

"2. . . euthanasia, when involuntary, is murder.

"3. . . God reserves for himself the right to decide at what moment a life shall cease?

"4. . . euthanasia violates the Biblical command, "Thou shalt not kill."

"5. . . suffering is a part of the divine plan for the good of man's soul, and must therefore, be accepted.

"6. . . patients pronounced incurable might recover after all, for doctors can and do make mistakes.

"7. . . patients racked by pain might make impulsive and ill-considered requests for euthanasia, if it were morally and legally approved.

"8. . . the moral and legal approval of euthanasia would weaken our moral fiber, tend to encourage us to minimize the importance of life.

"9. . . the ethics of a physician forbids him to take life.

"10. . . doctors do not want euthanasia made legal." 75

75 Fletcher, Morals and Medicine, pp. 190-205 passim.
Fletcher, however, does not touch all bases in the euthanasia issue. Daniel Maguire, associate professor of theology at Marquette University, sees the need for a healthier attitude toward death in our culture. He makes the following thought-provoking observations:

Man is the only animal who knows he is going to die, and he has borne this privileged information with uneven grace. . . . The average person, however, would rather forget it. This is especially true if the average person is an American since in this happiness-oriented land, death (outside of a military context) is seen as something of an un-American activity. It happens, of course, but it is disguised and sub rosa, like sex in Victorian England. Most Americans now die in hospitals. And they die without the benefit of the liturgies of dying that attend this natural event in cultures which accept death as a fact of human life. The dying process is marked by deceit, where everything except the most important fact of impending death can be addressed. When the unmentionable happens, the deceit goes or as the embalmers embark on their postmortem cosmetics to make the dead man look alive. Mourners, chemically fortified against tears that would betray the farce, recite their lines about how well the dead man looks when, in fact, he is not well and does not look it.

All of this does not supply the atmosphere in which man's moral right to die with dignity can receive its needed re-evaluation. . . .

. . . Where are the sacred borders between the can do and the may do?" 76

Offering support to Maguire is James Nelson who observes: "Our grandparents held things sexual to be unmentionable, but they spoke openly about death. We tend to reverse that order. Our playwrights have replaced deathbed scenes with bedroom scenes."

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77Nelson, Human Medicine, pp. 124-25.
Margaret E. Kuhn, speaking of healthy attitudes concerning death, in an address before the 1974 convention of the American Nurses' Association, informed the audience that young people are showing a tremendous interest in death and dying and that courses on death and dying have been popular additions to the curricula of colleges.

She stated:

Maybe the perceptive young in our society are seeing what we old folks knew—that all of life is precarious. There is gang violence and death on the streets. Instant death is present in plane crashes and auto smashups.

As an old person I have found in many of my peers a large degree of acceptance and calm readiness about death itself, but great anxiety about loneliness, disability, and abandonment—things that precede death. The people I know have as an ultimate goal to die with dignity. We all hope to "go quickly," "with out boots on." Universally, we hope and pray we can die on our own terms, with as much control as possible over the situation. Those whom I have interviewed strongly oppose extraordinary means of prolonging life—or, more accurately, the process of dying.

Besides these attitudinal considerations, Kuhn made some hard accusations. She points out that when we begin to die, much of what we suffer is related to the fears of the people around us—we are reminders to them that they too may sicken and die. Further these relatives and friends keep the truth from us and do not allow us therefore, to openly talk about death with those around us. Kuhn makes the statement "today death can be damned hard to come by. Death seems to take a permanent holiday!"

She lists what she calls the controversies and deceits that surround death and dying:

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79 Ibid., p. 187.
"1. The artificial prolongation of dying through medical technology and the prolongation of life through organ transplants.

"2. The economics of dying and burial—the immoral and immoderate expense of funerals and the way in which morticians capitalize on the grief and guilt of the survivors.

"3. The changed nature of dying and debatable definitions of death because of recent advances in medical knowledge and technology.

"4. Nagging and perplexing ethical questions about what medical science can and should do.

"5. The awesome responsibilities and power of doctors, nurses, and hospital administrators—powers of life and death over millions of Americans.

"6. The very sickness of our society that denies the reality of death.

"7. The rights of patients, particularly elderly patients who are the largest consumers of health services.

"8. The increased awareness among the elderly of their rights as patients and their responsibilities to make decisions about their lives, health, and well-being.

"9. The increased dissention in the ranks of medical societies and nurses' associations about euthanasia.

"10. The policy changes needed in the whole health delivery system." 80

The two issues which were chosen as examples for this paper—abortion and euthanasia—have been analyzed very simply. For in-depth analysis, the reader is encouraged to select from the bibliography at the end of the paper for some beginning readings in medical-moral problems. This simple analysis of two critical life issues can now be laid aside till chapter five, in which the role of the nurse-teacher will be discussed. Chapter four will consider the rights and responsibilities of the patient (client, consumer) and the nurse.

80Ibid.
CHAPTER IV

RIGHTS AND RESPONSIBILITIES

In the first chapter, it was stated that adult men and women, freely entering the nursing profession, must acquire knowledge and skills in the humanistic as well as the technical sciences. Their goals are to preserve health, to prevent disease, and to care for the ill and dying. To do this, they are called upon to counsel, guide, and instruct their clients in situations involving life issues. A life issue is defined as a human problem. It causes disequilibrium in the individual's internal or external environment. It requires a solution that is in conflict with the individual's own values and beliefs or is at odds with solutions acceptable by the majority of the population. It may require a solution within a prescribed period of time. Two examples of critical life issues were analyzed in chapters two and three: abortion and euthanasia.

Chapter four will consider the rights and responsibilities of the patient (client, consumer), the nurse, and the nurse-teacher. First, a brief definition of the words "right" and "responsibility" as used in this paper will be given. "Right" is a word with many meanings; it is a very flexible word. Webster's New World Dictionary defines a right as "that which a person has a just claim to; power, privilege, and so forth that belongs to a person by law, nature, or tradition." Some

1Webster's New World Dictionary, 2 ed. (1976), s.v. "right."
synonyms for right are prerogative, birthright, claim, and license.

"Responsibility" is defined by Funk and Wagnalls Standard Dictionary as "that for which one is answerable; a duty or trust." Synonyms are duty, accountability, obligation.

In order to determine the rights and responsibilities of patients and of nurses, various professional codes of ethics and other statements will be used as standards from which these rights and responsibilities can be inferred or delineated. Funk and Wagnalls define a code as "a system of rules and regulations for the purpose of ensuring adequate standards of practice and uniformity in workmanship." A code, therefore, specifies, in general terms, the responsibilities of a particular profession or group. It is from these responsibilities that the rights of the profession or group can be inferred.

But when it comes to determining the rights of the nurse-teacher, one encounters some difficulty. There are no codes written specifically for the nurse-teacher. The closest thing to a code, which a literature search was able to produce, was a list of "competencies deemed desirable in a teacher of nursing" in a dissertation by Alice Ruby Major in 1967 at Teachers College, Columbia University (see Appendix B). But competencies are skills which the nurse faculty member is expected to have if she is adequately to fulfill her role, and lists of competencies cannot be used in place of a code of ethics.

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3 Ibid., s.v. "code."

The nurse in her role as a teacher can be guided by the Code of Ethics of the Education Profession (see Appendix C), as formulated by the National Education Association of the United States (NEA). This code services a wide range of teachers (or educators as they prefer to be called) on the education spectrum—elementary teacher, secondary teacher, principal, dean, counselor, subject specialists. It is a general education code, and does not relate directly to the nurse-teacher as such. After a careful search of the literature, it was concluded that a "Code of Ethics for the Nurse-Teacher" is desirable and perhaps necessary. A code specifies broadly the responsibilities entailed in that particular role. From these responsibilities, rights can be inferred. Therefore, in addition to the need for a "Code of Ethics for the Nurse-Teacher," a "Nurse-Teacher Bill of Rights" can also be formulated as an adjunct to the code.

As stated earlier in the introduction to this chapter, the rights and responsibilities of the nurse, the patient, and the nurse-teacher will be analyzed. We will begin with the nurse.

The Nurse

"Nursing Education in the Seventies," a statement made in 1972 by the Board of Directors, National League of Nursing, succinctly defines the role and responsibility of nursing:

Although nursing's functions have always encompassed care, cure and coordination, its primary focus historically has been on care. Nursing's approach to service has been personalized and humanized. Nursing has nurtured and acted for the patient who is under stress and unable to cope satisfactorily alone. Nursing has been, for the individual, the most consistent and continuing point of contact with the health system.
At the present time, the perception of nursing's role and responsibilities is clouded by many ambiguities, as traditional distinctions between the functions of different health professions become blurred.

...nursing practice has become increasingly complex and nursing has taken on many functions that formerly lay exclusively within the domain of medical practice. This process is not reversible, and in fact many indicators point to its acceleration.

...nurses are being called upon to expand the scope of their practice.

Yet even though nursing responsibilities are evolving in response to the changing needs of society; the care functions remain constant. Nursing will continue to bear a unique responsibility for assuring a holistic, personalized, humanistic approach to the individual, family and community.

Some definitions concerning the nursing roles in clinical practice are necessary. The term "nurse" no longer signifies simply someone who cares for the sick. There has been a proliferation of terms as nurses have advanced in expanded roles. Unfortunately, these terms have tended to cause the definition to be confused among the public as well as the profession. The Congress for Nursing Practice has formulated the following definitions in the hope of removing some of the misconceptions associated with these terms:

Roles in Practice. Practitioners of professional nursing are registered nurses who provide direct care to clients utilizing the nursing process in arriving at decisions. They work in a collegial and collaborative relationship with other health professionals to determine health care needs and assume responsibility for nursing care. In the course of their practice they assess the effectiveness of actions taken, identify and carry out systematic investigations of clinical problems, and engage in periodic review of their own contributions to health care and those of their professional peers. In addition:

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5Nursing Education in the Seventies. A Statement by the Board of Directors, National League for Nursing, quoted in Being a Creative Faculty Member is More Than Teaching (New York: National League for Nursing, 1973), p. 68.
Nurse Practitioners have advanced skills in the assessment of the physical and psychosocial health-illness status of individuals, families or groups in a variety of settings through health and development history taking and physical examination. They are prepared for these special skills by formal continuing education which adheres to ANA approved guidelines, or in a baccalaureate nursing program.

Nurse Clinicians have well-developed competencies in utilizing a broad range of cues. These cues are used for prescribing and implementing both direct and indirect nursing care and for articulating nursing therapies with other planned therapies. Nurse clinicians demonstrate expertise in nursing practice and insure ongoing development of expertise through clinical experience and continuing education. Generally minimal preparation for this role is the baccalaureate degree.

Clinical Nurse Specialists are primarily clinicians with a high degree of knowledge, skill and competence in a specialized area of nursing. These are made directly available to the public through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. Clinical nurse specialists hold a master's degree in nursing preferably with an emphasis in clinical nursing. 6

Reference has been made to the expanded role of the nurse. This expanded role refers to the passing of functions from the physician to the nurse. The Model Practice Act Committee of The Congress for Nursing Practice states that this passing of functions from doctor to nurse represents only one dimension of the ongoing development of nursing in response to advancement in knowledge, technology and approaches to health care.

Helen K. Mussallem, executive director of the Canadian Nurses' Association, lists two additional changes involved in this expanded role of the nurse: (1) the expansion of the role to include caring for the patient's family and (2) the movement from the hospital setting to the home, clinic, and place of employment of the patient. She makes

one other observation: "Eventually, the nurse will be the only health practitioner who will provide continuous service in sickness and health as she now does in the hospital." Further, "she will move into this role not only because of pressures and social forces, but also because she will be prepared to do so and the best prepared to do so." Mussallem sums up her view of the nurse of the future by predicting that the new nurse:

1. Will be the person on the health team who works continuously and closely with families in sickness and health, moving freely between home and hospital.

2. Will not and cannot make a medical diagnosis, will not and cannot replace the medical practitioner, but will work cooperatively to utilize their scarce numbers to provide effective health service.

3. Will supervise the health of families and in the instances of illness, plan for their care in the hospital, using the specialized services of the physician and other health personnel in planning the total care.

4. Will utilize new technological advances so that her personal services may be used to the best advantage.

5. Will play a key role in assisting the medical or health team in translating new scientific discoveries into health care." With this brief review of the scope of nursing and the definitions of the various nurse positions completed, the rights and responsibilities of the nurse may now be considered. Claire M. Fagin, professor and chairman of the Department of Nursing, Herbert H. Lehman College, City University of New York, lists the rights of the professional nurse, as she sees them:


8Ibid.

9Ibid., pp. 516-17.
"1. The right to find dignity in self-expression and self-enhancement through the use of our special abilities and educational background.

"2. The right to recognition for our contribution through the provision of an environment for its practice, and proper, professional economic rewards.

"3. The right to a work environment which will minimize physical and emotional stress and health risks.

"4. The right to control what is professional practice within the limits of the law.

"5. The right to set standards for excellence in nursing.

"6. The right to participate in policy making affecting nursing.

"7. The right to social and political action in behalf of nursing and health care." 10

The nurse's legal right to practice and the scope of her responsibility are defined in nurse practice acts. Fagin cites the New York State Nurse Practice Act as an example. This act states that "nursing is diagnosing and treating human responses to actual or potential health problems, through such services as case finding, health teaching, health counseling, and initiation of health care."11

But there are other rights which are basic to the nurse, which are not mentioned by Fagin. To determine just what these other rights may be, we can examine the responsibilities of the nurse as stated in the Nightingale Pledge (see Appendix D) and from these responsibilities infer some additional rights. The pledge, of course, cannot guarantee these rights, but can recognize and acknowledge them.


11 Ibid., p. 85.
In this pledge, the nurse promises to "abstain from whatever is deleterious and mischievous," and "not take or knowingly administer any harmful drug." From these statements, the first right of the nurse can be inferred: the right to a sound, comprehensive basic nursing education program. If the nurse is expected to abstain from acts which would be deleterious or harmful to the patient, she must be aware of what is and what is not included in such acts. She can achieve this knowledge through a comprehensive basic nursing education program. A program which is built upon the art and science of nursing is necessary. Such a program entails the principles and practices which deal with (a) the physical well-being and care of the patient and (b) the mental, psychological, and emotional facets of his care as well. The nurse has the right to a program whose curriculum includes counseling techniques, teaching principles and skills, and courses in ethics.

The last statement of the pledge states: "devote myself to the welfare of those committed to my care." This can be interpreted to mean participation in the total care of the patient—physical, mental, emotional. Total care may involve the teaching and counseling of the patient, his family, and the community; therefore her second right is inferred: to act as teacher and counselor to the patient, the family, and the community. If the nurse has a responsibility for the total care of the patient, she therefore has the right to act as teacher and advisor to the patient, family, and community in matters which pertain to the nursing aspects of this care. In this role, she is called upon to counsel, guide, and instruct clients in situations involving life issues.
The third right of the nurse, and one which is closely interwoven with the second right, is the right to be a patient's advocate. In the 1976 Revised Code of Ethics for Nurses of the American Nurses' Association (ANA), the nurse: (1) provides services with respect for human dignity and the uniqueness of the client; (2) safeguards the client's right to privacy; (3) acts to defend the client and the public when health care and safety are affected by incompetent, unethical or illegal practice by any person; (4) participates in the profession's efforts to protect the public from misinformation and misrepresentation; and (5) collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public. Clearly, all five of these points from the Code envision the nurse as a representative of the patient, his family, and the community at large.

The fourth right of the nurse is to be held accountable and responsible for her professional actions and judgments. At first glance, it could be argued that "to be accountable" is a responsibility not a right. This is true. But in nursing, historically the physician and the hospital bore the burden of responsibility, not the nurse. Today, the nursing professional, independent of the physician and health institution, demands the right to be held accountable and responsible for her actions. The nursing Code declares that the nurse assumes responsibility and accountability for individual nursing judgments and actions; she maintains competence in nursing, and she exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others. The nurse then, as a professional, is
accountable for her actions. Nurses are no longer the physician's handmaidens, but equal partners with physicians and other members of the health team, and are equally responsible for their own actions. "To be held accountable," therefore, is both a nursing right and responsibility.

A fifth right of the nurse is the right to continuing professional education. If the nurse is to be held accountable for her actions, she must have access to programs which keep her proficient and in step with the advances of modern science and technology. As her role expands to include some practices which were previously those of the physician, she has a right to have access to educational programs which will prepare her for this expanded role.

In summary, the rights of the nurse, in addition to those rights as defined by Fagin earlier in this chapter, are:

1. The right to a sound, comprehensive basic nursing education program, in both the art and science of nursing.

2. The right to act as teacher and counselor to the patient, his family, and the community.

3. The right to be a patient's advocate.

4. The right to be held accountable and responsible for her professional actions and judgments.

5. The right to continuing professional education.

The responsibilities of the nurse are closely aligned with her rights. Ida Jean Orlando, in The Dynamic Nurse-Patient Relationship, looks at the conceptual meaning of nursing responsibility and makes a distinction between the responsibilities of the doctor and those of the nurse. According to Orlando, the practice of medicine is responsible for the prevention and treatment of disease. "The
responsibility of the nurse is necessarily different; it offers whatever help the patient may require for his needs to be met, i.e., for his physical and mental comfort to be assured as far as possible while he is undergoing some form of medical treatment or supervision." The nurse and physician do share some common ground. The nurse and physician are involved in a dynamic relationship with the patient: Both exists for him—without him, there would be no need for nurses or physicians. Orlando notes one important point that is applicable to physicians also:

Nursing in its professional character does not add to the distress of the patient. Instead the nurse assumes the professional responsibility of seeking out and obviating impediments to the patient's mental and physical comfort.  

Probably the most important element of this nurse-patient and physician-patient relationship is trust. Trust is defined by Funk and Wagnalls as "a confidence in the reliability of persons or things without careful investigation." If care and treatment are to be as successful as possible, the patient must have trust in those people responsible for his care. A patient, in so far as he is able, must cooperate in his care and treatment. The degree of cooperation by the patient is affected by whether he trusts those caring for him or not. Michael Jellinek, resident in Psychiatry, Massachusetts General Hospital, writes that the relationship between physician and patient is based on trust—"that the physician will do what is in the patient's

13 Ibid., p. 9.
14 Funk and Wagnalls, Dictionary, s.v. "trust."
best interest and will do no harm, that he will not abandon the patient in an emergency or once care has been undertaken, and that he will keep confidential all information about the patient. This resembles the Code of Ethics of the ANA (see Appendix E), so that where Jellinek uses the word "physician" one could in its place use the term "nurse."

Jellinek further adds that the concept of trust assumes a continuing, one-to-one relationship. The very heart of the nurse-patient relationship is also one which is based on a one-to-one relationship. But this relationship is not an unlimited one.

David Smith, in an address before the ANA convention in 1974, warns the nursing profession of the limitations of the nurse-patient relationship:

In the course of care, the patient-nurse bond may grow into a tie of friendship. But, in itself the professional bond is rightly limited and partial. The nurse who cares for me is concerned with the correct functioning of my body (or in the case of psychiatric care, of my mind).

...the nature of the nurse-patient bond shows that there are many dimensions of the patient's life in which the professional has no business meddling. Nurses' sovereignty over their patients must always be limited, a fact our society acknowledges as law in the right to refuse treatment.

The nurse exists to give care to patients. She is expected to meet their physical and mental needs (in so far as possible) when they cannot meet them by themselves. She is an equal partner with the physician and other health professionals in meeting the needs of patients.

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She has a unique relationship with the patient—one that is based on trust and one which is dissolved when the patient can once again meet his own needs. As a nurse she has (1) rights and responsibilities which pertain to her as a professional and, more specifically, (2) rights and responsibilities which pertain to the nurse-patient relationship.

The responsibilities of the nurse are outlined in the first code written for nurses, the Nightingale Pledge (the traditional nursing pledge), and the ANA Code for Nurses revised in 1976. The legal responsibilities of the nurse are spelled out in the various Nurse Practice Acts of the individual states.17

Throughout the analysis of the rights and responsibilities of the nurse, references were made to the patient and the nurse-patient relationship. Patient and nurse rights and responsibilities are often so closely interwoven that it is difficult to separate them. As the preceding section pointed out, the nurse exists to give care to patients. The next section will analyze the rights and responsibilities of the patient.

The Patient

A code of ethics as such does not exist for patients. Historically, the patient has only been "responsible" for cooperating with the medical treatment he has agreed to with his doctor. The patient has no

17The legal responsibilities of nurses vary according to the Nurse Practice Acts of the states in which they reside. While these responsibilities are not discussed in depth in this paper, they are a major area for research and study.
other responsibilities to any other members of the health team (nurses, therapists, and so forth). The area of patient responsibility then is rather a "cut and dry" matter. But the rights of the patient are a different question. Prior to the last five to ten years, little attention was given to the rights of the patient. In response to increasing concern of the health consumer and of a suit-conscious public, the American Hospital Association's (AHA) House of Delegates, in February 1973, approved a "Patient's Bill of Rights" (see Appendix F). This "Patient's Bill of Rights" was expressly developed to contribute to more effective patient care and greater satisfaction for the patient, for his physician, and for the hospital. The AHA, in the preamble of the "Patient's Bill of Rights" states:

...The Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. 18

Briefly, the "Bill" acknowledges the following rights of the patient (not all of the rights are listed below, see Appendix F for remainder):

1. Right to considerate and respectful care.

2. Right to information concerning his diagnosis, treatment, prognosis, and name of physician coordinating his care, in terms he can understand. When it is not advisable that such information be given to the patient, the information should be made available to an appropriate person in his behalf.


19Only those rights which directly address the patient's relationship with the health professionals are listed here. While the other rights of the patient are equally as important as the ones selected, they are not mentioned in this paper because they do not bear directly on the topic this paper is addressing.
3. Right to informed consent, except in emergencies, and to information about significant medical alternatives.

4. Right to refuse treatment to the extent permitted by law.

5. Right to privacy and confidentiality.

6. Right to know what hospital rules and regulations apply to his conduct as a patient.

Two "rights" referred to in the "Bill" are important ones for the purposes of this analysis--numbers two and six: the right to information concerning his condition and the right of the patient to know what hospital rules and regulations apply to his conduct as a patient. Number six specifically deals with a point made at the beginning of this section, that the patient, once informed about the treatment and agrees to it, has assumed a responsibility. Number two concerns the naming of an individual to act in behalf of a patient who cannot do so for himself. In essence, it is the appointment of a person who is responsible for safeguarding the rights of the patient. Terms commonly applied to such a person are patient representative, patient-advocate, and ombudsman.

In an article discussing the legal implications of this "Patient's Bill of Rights," George J. Annas, Director, Center for Law and Health Sciences, Boston University School of Law, and instructor in Legal Medicine, Boston College Law School, looks at the role of the patient-advocate which is currently a popular concept. He writes:

Among the ideas that merit discussion is the concept of "patient representative"--a person to whom the patient can go with complaints, get action from on a broad range of problems (both in and out of the hospital), and have him represent his interests in clinical conferences and other complex medical decisions. While "advocacy" seems to be the magic word these days--from "child
advocates" to "patient advocates"—the magic is not in the name but in function and performance. 20

While Annas appears to be in favor of the patient-representative concept, he points out that this "patient-representative" is usually and actually a "management representative," and that such personnel are primarily employed as a "public relations gimmick" rather than with the goal of "increasing the patient's ability to exercise his rights to take part in the medical decision making process about his body."21 He adds that if hospitals truly desire to increase the rights of their patients, they must act strongly to promote detailed bills of rights and make provisions for patient rights advocates with broad powers to act on behalf of patients and to enforce these rights.

The profession of nursing concurs with Annas concerning the merit of the concept of patient-advocate but adds that the nurse has always been the patient's advocate. This feeling is clearly expressed in the 1976 revised nursing Code of Ethics (see Appendix E): "the nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person."22 Before assuming the presidency of the American Nurses' Association (ANA) in June of 1976, Anne Zimmerman, in a television interview, stated that the nurse has always been the patient's advocate.


This is a position that this writer endorses because: it is the nurse who spends the most time with the patient; it is the nurse who coordinates his care; and, in general, it is the nurse who is responsible for his care, safety, and well-being.

Interest in the patient and his welfare is evident in two other nursing codes—the earliest, the Nightingale Pledge, formulated in 1893 (see Appendix D) and a later International Council of Nurses Code of Ethics, formulated in 1965 (see Appendix G). Since the first pledge was formulated, many codes have been developed and revised to meet the needs of a changing profession and a changing society. In 1976, the American Nurses' Association last revised its Code for Nurses. Kathleen Sward, associate professor, School of Nursing, State University of New York, and chairperson of the ad hoc committee of the Congress for Nursing Progress, notes that the 1976 code (Appendix E) differs from previous codes (this revision is the fourth since the code was adopted by the ANA in 1950) by placing less emphasis on the nurse herself and more on the nurse's relationship to the client. Sward, in addition, noted that "the Congress for Nursing Practice was quite conscious of the increased national interest in ethics."23

This new emphasis on the nurse-patient relationship, rather than on her responsibilities as a professional, is highlighted in the preamble statement of the 1976 Code:

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24Ibid.
Recipients and providers of nursing services are viewed as individuals and groups who possess basic rights and responsibilities, and whose values and circumstances command respect at all times.  

The code emphasizes the importance nursing places on the patient as an individual, in the first statement of the code:

> The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.  

This assertion that the patient is the focal point in health care is paralleled by the AHA's Patient's Bill of Rights' first statement: "the patient has the right to considerate and respectful care."  

The code, again paralleling the AHA "Bill," acknowledges the right of the patient to privacy and confidentiality (statement two, ANA Code; statements five and six, AHA "Bill"). Also, the individual's right to privacy, though not explicitly mentioned in the United States Constitution, is protected by the Bill of Rights of the United States and the due process clause of the Fourteenth Amendment.

The other code of nursing ethics, referred to earlier, the International Council of Nurses Code of Ethics (see Appendix G) recognizes the following rights of the patient, in addition to the rights acknowledged in the ANA code:

a. The right to a physical, social and spiritual environment which is conducive to recovery,

26Ibid., p. 3.  
27AHA, Patient's Bill of Rights.  
28O'Rourke, "The Right of Privacy," p. 58.
b. The right to education and example in the areas of prevention of illness and promotion of health,

c. The right to health services, not only for himself but also his family and the community,

d. The right to the preservation of his life, 29

e. The right of freedom.

Both of the above mentioned codes are general in nature and apply to all nurses. An example of a code more specific in nature is the guidelines developed by the ANA Commission on Nursing Research: "Human Rights Guidelines for Nurses in Clinical and Other Research," which was completed in early 1975. 30 This Commission publicly reaffirmed the nursing profession's obligation to support the advancement of scientific knowledge. In doing so, the ANA accepted a commitment to support two sets of human rights:

29 William H. Baughman, writing in Notre Dame Lawyer, summarizes the legal position of the individual to preserve his life: "...common law belief in the sacredness of life is so absolute and pervasive that it even protects those who are dying." Baughman quotes the following decision (Blackburn v. State, 23 Ohio St. 146, 163 (1872): "The life of those to whom life has become a burden--of those who are hopeless dying or fatally wounded--. . .are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment. . . ."

30 These guidelines are of particular importance in the areas of the patient's right to informed consent and of his right to be treated as an individual. The guidelines state very clearly: "each practitioner of nursing has an obligation to endorse and support self-determination as a moral and legal right of the individual."
One set is concerned with the rights of qualified nurses (those with research preparation) to engage in research and to have access to resources necessary for implementing scientific investigations. The other deals with the human rights of all persons who are recipients of health care services or are participants in research performed by investigators whose studies impinge on the patient care provided by nurses. The need for the establishment of human rights guidelines for nurses came as a result of social and technological changes that altered nursing and nursing practice. 31

In addition to the codes of the nursing profession and the AHA's Patient's Bill of Rights, the physicians have two guides to professional conduct: (1) a Code of Ethics (see Appendix H) and (2) the Oath of Hippocrates (see Appendix I). In their Code of Ethics, the medical profession recognizes the same rights of the patient as does the nursing codes and the AHA's Patient's Bill of Rights—the right of the patient to dignity, confidentiality, competency, and service.

With regard to the patient's other rights, the Hippocratic Oath offers two statements which appear to be in opposition to the patient's right to control what happens to his body. The first statement reads "I will give no deadly medicine to anyone if asked, nor suggest any such counsel," and the second, ". . .I will not give to a woman an instrument to produce abortion."32

Since the Supreme Court ruling legalizing abortion, the second statement is also contrary to current law. Both statements are relevant to the topic of this paper: abortion and euthanasia. The modern physician is faced with a dilemma: to follow the oath and ignore or


disobey the law; or to ignore the oath and obey the law. As stated in chapter one, in the statement of the problem, it is not that the health professions are faced with new problems (for abortion and euthanasia are age-old) but rather the choices for solution are new and often radical.

Some say that the Hippocratic Oath is no longer applicable. Jane Clapp, author of Professional Ethics and Insignia, writes of the Oath: "Today—if taken at all—the oath is administered at the graduation ceremony of a medical school."33 In seeming support of the view that the Hippocratic Oath is no longer applicable, the Right Honorable, Lord Ritchie-Calder, Chairman, Metrication Board, and Former Professor of International Relations, University of Edinburgh, Edinburgh, Scotland, states: "The Hippocratic Oath, noble in its intention, no longer serves. It has been overtaken by events... In the phrase of the biophysicist LeRoy Augenstein, 'the physician is being asked to play God.'"34

It can be seen from these various codes and statements, that many have addressed themselves to the rights of the patient (see Appendix for other codes and position statements which, while not cited in this paper, may be of interest to the reader).

In summary, the following rights of the patient, are acknowledged by the major codes and statements of the nursing profession, the medical profession, and the hospital associations, and are generally

33Ibid., p. 563.

accepted by the other health professionals and the public:

a. Right to be treated with dignity.

b. Right to confidentiality.

c. Right to privacy.

d. Right to competent care.

e. Right to informed consent.


g. Right to complete current information concerning one's condition.

h. Right to know what hospital rules and regulations apply to his conduct as a patient.

Both the right to privacy and the right to confidentiality are guaranteed by the Ninth and Fourteenth Amendments of the United States Constitution. Informed consent basically involves the giving of necessary information to the patient and the gaining of his consent. The information must include risks involved and other alternative treatments that are available.

Other rights of the patient acknowledged by the health professions, in their codes, but which are not generally accepted by the public and some of the health profession members are:

a. Right to health service and treatment.

b. Right to an environment--physical, social, spiritual--conducive to health.

c. Right to health education and counseling.

d. Right to representation by a guardian or advocate (if necessary).

The main objection to the first three rights is an economic one. It is argued, by economists and insurance companies among others, that we cannot afford the price tag attached to such care. While it is
generally acknowledged that the patient has a right to treatment in a "good" health environment, the quality of such treatment and what makes up a "good" health environment, are in dispute. One only has to look at the cost of the Medicare Program to get a first-hand view of the cost problem. Another example is the cost of intensive care. Coronary care beds in hospitals cost anywhere from one hundred dollars per day to over three hundred dollars per day and that does not include drugs, treatments, or physician fees. (The reader interested in costs of hospitalization in the United States is referred to the American Hospital Association, for national figures.)

The last right—the right to a patient-advocate, while currently a popular idea and one which is sweeping across the country's hospitals, still is not accepted by all. Some professionals argue that it is nothing more than another person to deal with, an unnecessary "middleman." Patients are more inclined to accept the patient-advocate, since many patients and their families are mistrustful of hospitals, doctors, insurance companies, and governmental agencies.

The rights which are not generally accepted by the health professionals and the public and which are emotionally charged and hotly disputed are:

a. Right of control over one's body.

b. Right to life.

c. Right to die.

Needless to say, these may be in opposition to each other—such as in pregnancy the fetus has the right to life, but the pregnant woman has the right to control what is happening to her body.
The crux of the problem, among these three rights, is the first one: the control over one's body. Is this control unlimited? Baughman and associates look at the legal position:

The right to control one's own body seems to enjoy some constitutional protection as an offshoot of the right of privacy. The states may curtail this right. In fact, the Constitution may require the states to intervene to protect a fundamental right of greater significance. But if the interest justifying state interference ceases to be compelling, the states can and indeed must revise the law to reflect this change. Recent revisions in abortion laws, originally passed to protect women from an operation at one time dangerous but now medically safe, demonstrate such an atrophy of a compelling state interest. Nevertheless, the states may not remove safeguards to fundamental constitutional rights utilizing this rationale, as the states always have a compelling interest in protecting such freedom. 35

Recognition of the right to life, according to Baughman and associates, predates the Constitution and received recognition in the Declaration of Independence as an "inalienable" freedom. They point out that "although the Constitution does not expressly mention it, the Fifth and Fourteenth Amendments contain guarantees against the taking of life without due process of law."36 They add "American law has established few instances in which the taking of life is permissible," and "under the American justice system, neither individual nor government may take human life without presenting considerations more significant than the right to life itself."37

Of the right to die, Baughman and associates cite the right to privacy, derived from the Ninth and Fourteenth Amendments, as a

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36 Ibid., p. 1247.

37 Ibid.
possible safeguard against state-imposed measures to prolong life for those near death who wish to die without delay. Again, citing this right to privacy, they write:

Recent cases utilizing the right to privacy to uphold personal liberties seem to indicate the recognition of a right to control one's own body. The common law acknowledges this prerogative, protecting the individual from undergoing medical treatment to which he has not consented, except in emergency situations where the patient is unable to give consent. In Erickson v. Dilgard the court made clear its belief that a competent adult could not be forced to endure unwanted treatment, even though the best medical opinion might consider it essential to prevent death. 38

Euthanasia, active and passive, voluntary and involuntary, were discussed in chapter three. Its religious, social, and legal considerations were also analyzed in that chapter. Baughman and associates, looking at the sanctity of life, the right to die, and the right to control over one's body, state:

There so exist, and courts have recognized, certain compelling interests overriding the right to control one's own body. These interests may not appear so substantial, however, when examined in light of those suffering from terminal or incurable disease desiring premature death. American society strongly affirms the sanctity of life and, therefore, no fundamental right could probably stay the hand of the state from prohibiting terminal patients from employing active measures to prematurely terminate life. Such persons may, however, enjoy the right to refuse both ordinary and extraordinary treatments designed to prolong existence.

... That refusing extraordinary treatment does not endanger the sanctity of life can be shown by looking at the pronouncements of the Roman Catholic Church, one of the most vigorous advocates of the sanctity of life in this country. Pope Pius XII, addressing a group of physicians in 1957, remarked that Christian ethics do not require the administration of extraordinary treatment to patients where life is ebbing hopelessly. The Pope indicated that this statement referred to terminating extraordinary procedures already begun as well as refusing those not yet undertaken. 39

38Ibid., p. 1239.

39Ibid., p. 1242.
I conclude that the right to control over one's own body is not an unlimited one; that the right to life is a fundamental inalienable one; and that informed consent and right to refuse treatment are rights of all individuals. I am also in agreement with the statement of Pius XII concerning the use of extraordinary means to preserve life.

Up to this point, only the rights of the patient have been addressed. What are the responsibilities of the patient? Here the codes do not seem to be of any assistance. Perhaps only one statement in the AHA's Patient's Bill of Rights offers any hint of responsibility on the patient's part: "the patient has the right to know what hospital rules and regulations apply to his conduct as a patient." It can be interpreted to mean that if the patient knows what is expected of him and he consents to be treated in a particular hospital or health setting, then he must abide by its rules of conduct. Further, if a patient gives an informed consent, he is responsible for cooperating with the forms of treatment agreed to. This consent, in the hospital setting at least, is given in the form of a permit for treatment or for operative and diagnostic procedures. There appears to be no other area of accountability for the patient.

It can be seen that it is difficult to separate the rights of the patient from others who are closely interacting with him. The patient must relate also to his family, his doctors, other members of the health team, and the community. Consequently, the rights of the patient, the recognition of these rights, go beyond the relationship which is being dealt with specifically in this paper. While hospitals and physicians have been mentioned in connection with the rights of the patient, only the rights and responsibilities of the nurse so far have
been analyzed. But one other person is important to the patient, at least indirectly, and that is the nurse-teacher. The next section will analyze her role in relation to the patient-nurse bond. Other relationships of the patient (physician, hospital) will not be addressed in this paper.

The Nurse-Teacher

Chapter four is concerned with the rights and responsibilities of three persons: the patient, the nurse, and the nurse-teacher. In looking at the patient and nurse, a review of the codes of ethics of the nursing profession, the medical profession, and the hospital field was used as a basis for determining the rights of the patient and of the nurse. The rights and responsibilities of the teacher of nurses cannot be analyzed in this same fashion, since no codes of ethics are directly applicable. There are codes for the nurse—the Nightingale Pledge, the ANA Code for Nurses, and the International Code for Nurses to name a few. There is also a code for teachers—The Code of Ethics of the Education Profession as formulated by the National Education Association (NEA). While all these codes may apply to the nurse-teacher totally or partially, not one of them is designed specifically for the nurse-teacher. What is needed, then, is a Code of Ethics for the Nurse-Teacher and a Teacher Bill of Rights. Before trying to

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40 The NEA code was formulated for persons engaged in all aspects of public education. This code also recognizes the worth and dignity of man. In the preamble, it recognizes also the importance of the pursuit of truth and of devotion to excellence. The code has four principles which give the general commitment of the professional educator to the student, the public, the profession, and to professional employment practices. The code is referred to again in chapter five.
determine those rights and responsibilities which are specific to the nurse-teacher, her relationship to the patient-nurse bond must be made evident.

The relationship of the nurse-patient can be diagrammed as follows:

This relationship--nurse-patient--is the basic building block of the nursing profession. The student nurse, likewise, has a relationship with her teacher. This relationship, similar to that of the patient-nurse, can be diagrammed as follows:

This relationship--nurse-teacher of nurses--is the basic building block of nursing education. This relationship can now be added to the nurse-patient relationship, and diagrammed as follows:
Step I

INDIRECT --- A CARING RELATIONSHIP

TEACHER

HELP

← NEEDS

STUDENT

AN EDUCATIONAL RELATIONSHIP

Step II

CARE

TEACHER ← STUDENT NURSE ← PATIENT

CARE

TRUST

TRUST

CARE

TRUST

It can be seen that the relationship between student and teacher is very similar to the relationship between patient and nurse. The rights and responsibilities of the patient-nurse relationship have already been analyzed by using the various codes of ethics and position statements of the professional health care organizations, such as ANA, the AMA, and the AHA. These codes, while somewhat applicable to the nurse-teacher, do not adequately address her rights and responsibilities directly.
Clearly there is a need for the rights and responsibilities of
the nurse-teacher to be formulated and specified. Based on my experi­
ence and research, I propose a "Nurse-Teacher Bill of Rights" and a
"Code of Ethics for the Nurse-Teacher." Chapter five will present
these two proposed statements.

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As a former nursing school faculty member, staff specialist for
the American Hospital Association, responsible for the Assembly of
Hospital Schools of Nursing of the AHA, nursing education tutor, and
In-Service Director for a hospital, I have studied many codes of ethics
(many of which are included in the appendices) and have consulted with
numerous nurse-teachers, nurses, and patients. From these experiences
and contacts, I have concluded that there are rights which are specific
to the nurse-teacher.
CHAPTER V

THE NURSE-TEACHER

The preceding chapter considered the rights and responsibilities of the nurse, the patient, and the nurse-teacher. It was concluded that there is a need for the rights of the nurse-teacher to be isolated and identified, and further, that there is a need for a code of ethics which is specific for the nurse-teacher. The teaching of student nurses by a faculty which consists primarily of nurse-teachers rather than physicians is a relatively modern concept. Unfortunately, many nurse-teachers have not been prepared to teach, let alone teach nursing ethics. Previous to the first nursing position paper on education released in 1965 (referred to in chapter one), many nurses were teaching without even the basic prerequisite of a bachelor's degree. Many were selected because of their experience in a clinical area or to fill a desperate need. If the nurse-teacher had a bachelor's degree, she was often placed in a teaching position, regardless of the subjects she majored in or her ability to teach.\(^1\) It is only within the last few years that nursing education, in general, has stressed the need for nurse-teachers to be educated at the master's level and with majors in the areas that they will be teaching. The position of nurse-teacher

\(^1\) Statistics on educational preparation of nurse-faculty are available from the National League for Nursing, 10 Columbus Circle, New York, New York, 10019.
then, is a new one— one in which much research and exploration needs to be done.

In order to identify the role of the nurse-teacher, it is necessary to ask: what are the responsibilities of such a person? What rights belong to her? Using the same process as was used for determining the rights of the nurse and of the patient, I propose first to formulate a code of ethics for the nurse-teacher, and second, to determine her rights. As stated in the conclusion of chapter four, based on my experiences in nursing education, I have concluded that these two statements for the nurse-teacher are not only desirable, but necessary. The "proposed code of ethics for the nurse-teacher" will be presented first.

**A Proposed Code of Ethics for the Nurse-Teacher**

The nurse-teacher has a direct relationship to the student nurse. Through this relationship, the nurse-teacher also assumes a direct and indirect relationship with the patient, his family, the physician, other health professionals involved in the patient's care, and the community. What she teaches and how she teaches can affect, in varying degrees, all of these people. The prescriptions offered in this code are justified because of the responsibilities incurred by the nurse-teacher in these various direct and indirect relationships.

**Preamble**

The nurse-teacher devotes herself first to the welfare of the patients (clients) committed to the care of her students. Secondly, as a teacher of nurses, she is committed to the welfare of her students. She respects the rights of students and of patients. She assumes the
responsibilities both of the role of nurse and of the role of teacher—both roles are built on a trust relationship between her and her patients and her and her students. The patient trusts that he will receive the care he needs; the student trusts she will receive the educational preparation that she needs.

The nurse-teacher recognizes that she is directly responsible for the quality of care given to the patient (client) by her students, and indirectly responsible for the quality of care given by her students later as professional practitioners of nursing.

The nurse-teacher, therefore, recognizes her commitment to the student, to the patient, to the patient's family, to the physician, to other health professionals, and to the community.

Commitment to the Student

The nurse-teacher works toward the development of the student's potential. In fulfilling her obligation to the student, the nurse-teacher:

1. Shall create an educational climate which is conducive to learning and shall instill in the student a spirit of inquiry through use of the scientific method and the nursing process.

2. Shall encourage independent action and creativity.

3. Shall expose the student to both the science and art (theory and practice) of nursing.

4. Shall foster the interdisciplinary (team) approach to patient care.

5. Shall not suppress or distort the subject matter for which she bears responsibility.

6. Shall recognize that she is not the sole authority of subject matter and shall use other professionals to ensure a high quality of program content and expertise where appropriate.

7. Shall include in program content, the counseling and teaching knowledge and skills necessary for the student to contribute to the total care of the patient.
Justificatory and Interpretive Statements

It is the right of every student, whether in nursing or not, to an educational climate which is conducive to learning and one in which his potential can be developed to the fullest degree possible. The educational climate, while affected in varying degrees by physical structure, is not restricted to it. The teacher is the main and guiding force of the educational milieu. It is the teacher who can encourage independent activity and creativity, or destroy it. In nursing, the teacher of nursing students has two educational milieus to function in: the classroom and the clinical setting.

The nurse-teacher must recognize that nursing is a "doing" or "hands-on" profession. While the stress today is on nursing theory and the development of a nursing body of knowledge, the nurse-teacher must not forget that nursing is also an art, and students must have an opportunity to practice their art under the guidance of the faculty. Further, nursing is more than the physical care of the patient; it is to an increasing degree the instruction of the patient in health care and the counseling of the patient and his family in many diverse types of situations. The issues discussed in this paper alone—abortion and euthanasia—are prime examples of critical life situations in which nurses may play a major role in the teaching of or counseling of patients and families. Because the nurse is becoming more responsible in the areas of teaching and counseling, she must be taught the principles of learning, teaching and counseling and be given an opportunity

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2See chapter six, euthanasia studies by Brown, Thompson, Bulger and Lays, and abortion studies by Anderson and co-authors.
to practice these skills under proper supervision.

The interdisciplinary approach to patient care should be fostered by the nurse-teacher for many reasons. First, it is imperative that the student be exposed to many views, especially in the area of disputed issues such as abortion and euthanasia. As science advances, beliefs and values may be altered. In his introductory comments about future shock, Alvin Toffler states: "In three short decades between now and the twenty-first century, millions of ordinary, psychologically normal people will face an abrupt collision with the future."[^3] Secondly, the nurse cannot be "all things to all people." She must understand herself and her own limitations. She should be encouraged to strive for new approaches and avenues of thought and to take advantage of opportunities to work closely with other disciplines. Thirdly, the nurse-teacher must recognize that her views and positions concerning health education and issues, may have a profound effect on many lives. The effects of the teacher-student relationship do not end when this relationship is ended. The graduate nurse carries with her into her professional life many of the concepts instilled in her by her teachers. This carry-over affects the nurse and her patients.

**Commitment to the Patient**

The nurse-teacher recognizes the right of the patient to considerate and respectful care. She recognizes that the patient has the right to receive the necessary information concerning the identity of the people caring for him. She recognizes the student-patient-teacher relationship.

relationship and assumes the responsibilities involved in this relationship. In fulfilling her obligation to the patient, the nurse-teacher:

1. Shall safeguard the patient's right to safe care by competent academic preparation and supervision of the student assigned to her care.

2. Shall safeguard the patient's right to informed consent by obtaining (when possible) the patient's consent before using him in the learning situation.

3. Shall safeguard the patient's right to privacy by judiciously protecting information of a confidential nature, and by using this information only in the educational setting.

4. Shall assume full responsibility and accountability for the students under her supervision.

5. Shall ensure competent care of the patient by keeping her own knowledge and skills at a consistently high level.

6. Shall ensure that the care (physical, mental, emotional) given by her students, is not biased, incompetent, or incomplete.

Justificatory and Interpretive Statements

The nurse-teacher protects the patient and ensures his safety while he is being cared for by the students under her direction. The nurse-teacher is accountable for the actions of her students in the area of patient care. To provide safe care for patients, faculty as well as students, must be academically and clinically prepared at appropriate levels and degrees. The nurse-teacher must be involved, formally or informally, in programs of study to ensure her quality of instruction and personal self-development.

The rights of the patient are protected by the nurse-teacher in the areas of informed consent, privacy, and confidentiality. The patient should be informed that he is being taken care of by a student nurse, and should have the right to refuse this care if he so desires.
The patient’s identity is protected in all reports, case studies, conversations, and other educational activities conducted by the student nurse and by the nursing faculty. The patient’s name and other identifying information should be coded whenever possible.

Commitment to the Family

The nurse-teacher recognizes the basic unit of society—the family. She recognizes the importance of the family in the total care of the patient (client). She recognizes the importance of the family to the patient, and of the patient to his family. In fulfilling her obligation to the family, the nurse-teacher:

1. Shall include the concept of family in her education of the student.
2. Shall seek their consent and participation whenever appropriate.
3. Shall encourage the formation of meaningful relationships between the student, patient, and family.

Justificatory and Interpretive Statements

Anderson, Camacho, and Stark, in a chapter entitled "The Family and Roles of Its Members," write of the family:

Since the beginning of history, the most widely shared characteristic of the human race has been its ability to organize into family groups. Indeed, it is through the family that society endures and constantly regenerates itself culturally and biologically; it is the family that helps mold and adapt its members to established social norms and mores; it is the family that provides the individual with a sense of protection, security, and love. 4

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Most patients are part of a family. The patient's family can be a great influence in his life; therefore, in order to give the most comprehensive care possible to a patient, the family cannot be forgotten. The family may have a negative effect on the patient. The patient may not wish to recognize the family. Negative as well as positive family relationships affect the care of the patient.

The field of pediatrics has always recognized the patient(child)-parent-nurse triangle. Blake and Wright, in their pediatric nursing textbook, state: "Hospital personnel have come to regard the child and his family as mutually dependent on each other." The pediatric nurse is taught that the child-parent relationship is one which must be nurtured and supported during illness; that in most cases, the child cannot be treated without taking into account his parents. Likewise, when we treat the adult, we may also find another triangle—that of the patient-family-health professional.

Commitment to the Physician and Other Health Professionals

The nurse-teacher recognizes the close relationship between the practice of medicine and the practice of nursing. She further recognizes the contribution of the other health professions in the total care of the patient. In fulfilling her obligation to the physician and other health professionals, the nurse-teacher:

1. Shall foster harmonious relationships between the patient and the physician.

2. Shall foster the interdisciplinary (team) approach to total patient care.

3. Shall develop a cooperative and harmonious relationship with the physician.

4. Shall assume responsibility for the care given to the physician's patients by her students.

5. Shall foster harmonious relationships with other health professions.

Justificatory and Interpretive Statements

Traditionally, the physician has been the "captain of the ship." As science has advanced and proliferated new data and theories, it has become virtually impossible for any one person to know all there is to know on any one subject. One result of this staggering amount of knowledge that modern science and technology have produced has been the team approach to health care. Although the majority of physicians still clutch the "captain" concept, other health professionals (dentists, pharmacists and many physicians) are looking to an interdisciplinary (team) approach to care of the patient (also to the education of health professionals). Leslie A. Falk, professor and chairman, Department of Family and Community Health, Meharry Medical College, quotes, along with his associates, the definition of "comprehensive health care" by Weinerman and Snoke, in which the concept of the team approach to health care is clearly stated:

"Comprehensive health care is the organized provision of health services to the entire family, including a full spectrum of service from prevention through rehabilitation, continuity of care for the individual, emphasis on the social and personal aspects of disease and its management, use of the health team concept with personal physician responsibility, and coordination of the diverse elements of modern scientific medical practice."

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One patient may be seen by a physician, a nurse, a social worker, a respiratory therapist, a clergyman, and a vocational therapist. All of these professionals may contribute to the patient's total care program. At present, in most situations, the physician is still considered the leader of the team. This position is being questioned. Some health professionals feel that, while the physician may be the team leader, it is not automatic that he be so. It is conceivable, that the leader could be the person who best can coordinate the patient's care at a given time.

At this period in the care of the patient, it is not the question of who will be the "captain" of the team, but rather, of whether the patient has a right to the expertise of health professionals as needed in addition to the expertise of his physician. In the team approach to health care, all professionals involved are peers and have a cooperative relationship with the physician.

Commitment to the Community

The nurse-teacher recognizes her responsibility to the community as a teacher of future health professionals. She recognizes both her duty to instill in her students concern for the public and the student's obligations to meet the health needs of that public. In fulfilling her obligation to the community, the nurse-teacher:

1. Shall instill in her students concern for the needs and wishes of the health consumer.

2. Shall promote the education of the public in matters of health—mental, physical, emotional.

3. Shall never knowingly or deliberately distort or suppress information to be given to the public.
Justificatory and Interpretive Statements

The nurse no longer is associated with caring for the sick in hospital settings only. She renders care where the patient is—at home, in the hospital, on the job, in the community. Just as the family unit is recognized, so too is the group—the community in which the family functions. Nursing education recognizes the sociological aspects of health care and strives to meet the changing needs of the community. To meet these changing needs, nurses must take an active role in community health. Mary Cipriano Silva, former instructor at Case Western Reserve and Stanford Universities, writes of the nurse:

"Nurses must recognize that the direction of scientific discovery and its application to mankind is not out of our hands. On the contrary, they have a personal and professional responsibility to ask probing questions about scientific and technological research."7

This proposed code of ethics is patterned after the Code of Ethics of the Education Profession. It is patterned after this particular code deliberately. The nurse-teacher, in her role as teacher, can be guided by the principles of the education code. As a teacher of nursing, the proposed code is an adjunct to the education code and one which is specific to the teacher-student nurse-patient relationship.

The proposed code outlines the responsibilities of the nurse-teacher. The rights of the nurse-teacher can be inferred from these responsibilities and are presented in the next section in the Proposed Nurse-Teacher Bill of Rights.

A Proposed Nurse-Teacher Bill of Rights

The nurse-teacher has:

The right to the opportunity to know herself, her capabilities, her assets, her liabilities, her values, her philosophy.

The right to an educational program designed to prepare her not only to be a specialist in her area of study, but also as a health teacher and counselor.

The right to an interdisciplinary approach in her academic preparation as a teacher of nurses.

The right to refuse to teach subjects which she is not qualified by academic preparation or experience to teach.

The right to programs designed to prepare her in the area of teaching critical life issues.

Justificatory and Interpretive Statements

Right I. The right to the opportunity to know herself, her capabilities, her assets, her liabilities, her values, her philosophy.

The right to "know yourself" is not a unique one to the teacher of nurses. Basic students in nursing have been taught from their first nursing courses, that if they are to help others, they must first understand their own selves. Major, in her dissertation, writes "she [the nurse] should maintain command of a considerable body of concrete information about her world, her culture and herself. . . ."8 This aspect of the teacher of nurses becomes vital when the individual is involved in teaching student nurses how to counsel clients involved in critical life issues. Clearly, the nurse's frame of reference, her philosophy and values, will influence her functioning in this highly sensitive area. To know one's self, involves knowing one's philosophy

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8Major, "The Teacher of Nursing," p. 42.
--to know where one is going and how one will get there. Her philosophy determines her attitudes and personal code of conduct.

Other professions such as social work and psychology are in support of the importance of self-knowledge. Major quotes Margaret Lindsey, author of New Horizons in the Teaching Profession: "What the professional educator is and does as a person is a dynamic factor in every educational function he carries out. His effect on others is contingent on his behavior as a person." 9 Merton, Reader, and Kendall, in The Student-Physician, write that just as a sick person may be significantly affected by his social ties, by his situation within the family and workplace and in other groups important to him, so too must the development of the medical student be considered in the light of his social and psychological environment. 10

While this right may seem basic, apparently not all nursing programs allow this right. Richard Drake, assistant professor, Brigham Young University, writes: "...I am appalled at faculty members in institutions of higher learning who cannot accept the individuality of the student and who actually punish the learner for asserting herself." 11

Therefore since the nurse-teacher may affect the lives not only of her students, but also of the patients, these same students as professional nurses will be taking care of, it is necessary and legitimate

9 Margaret Lindsey, New Horizons in the Teaching Profession, quoted in Alice R. Major, "The Teacher of Nursing" (Columbia University, 1967), p. 44.


to recognize and acknowledge her right to self-knowledge. 12

Self-knowledge and the development of the nurse-teacher as a professional teacher of nursing can be accomplished through formal and informal continuing education. Gertrude Torres, consultant in nursing education for the Department of Baccalaureate and Higher Degree Programs of the National League of Nursing, supports the right of the nurse-teacher to opportunities for self-development. In a workshop panel discussion addressing faculty-curriculum development, she stated:

One of the things . . . administrators in nursing education need to truly believe in is continuing education for faculty. Frequently you will find deans or administrators supporting the mandating of continuing education in the state, but having little or no funds or time available for faculty to engage in such activities. 13

Dr. Torres highlights the two problem areas in the continuing education of faculty: time and money. While most administrators of colleges and schools of nursing believe in the need for continuing education of the nursing faculty, they frequently lack the financial support of the college or school administration. With a restricted budget, faculty members may be carrying more courses than are desirable (from the faculty viewpoint at least) and thus lack time to participate in self-

12That the nurse’s own philosophy and values affect others is held by many educators and health professionals. Among these are Marguerite Lucy Manfreda, author of a basic psychiatric nursing text; Charles K. Hofling, assistant professor of Psychiatry, University of Cincinnati, and Madeleine M. Leininger, associate professor of Psychiatric Nursing, University of Cincinnati; and pediatric nursing authors Philip C. Jeans (State University of Iowa), F. Howell Wright (University of Chicago), and Florence G. Blake (University of Chicago).

development programs. Many nursing education administrators have recognized this need for continuing education and have established a faculty development program which provides for funds and time. These programs vary as to what is expected of the faculty and what kind of support will be offered by the administration to the faculty members.¹⁴

Right II. The right to an educational program designed to prepare her not only to be a specialist in her area of study, but also as a health teacher and counselor.

Nurses have been taught, and with increasing emphasis, that their function is not limited to physical care, but includes counseling and guidance of the patient, his family, and the community. But who teaches her these teaching and counseling skills? Nursing faculty, often ill-prepared themselves in these skills, have attempted to teach these skills to their students and thus have perpetuated the problem of nurses being educated superficially in these skills. There is a need for experts from the fields of communication, education, counseling and guidance to be added to nursing faculties. Curricula need to be developed so that the student may acquire the basics in the areas of teaching and counseling.

¹⁴The Evangelical School of Nursing in Chicago, in their Faculty Personnel Policies, state: "A faculty status report completed annually gives evidence of the professional growth and development of each member. The Curriculum Coordinator assists faculty growth by having conferences with each faculty member annually. . . A program of continuing education is provided during the school year which all faculty members attend. Attendance at workshops, conventions, etc. is encouraged . . . Individual academic courses taken by faculty will be approved by the Faculty Personnel Committee. . . upon successful completion of approved courses. . . toward academic degree, full time faculty will be reimbursed for costs of full tuition for a maximum of one course per quarter. . . or a total of two per year." (The writer thanks Elida Mundt, Director of the Evangelical School of Nursing, for supplying this information.)
Few nursing programs stress the need for the student to obtain the skills needed to teach and counsel. Emphasis has generally been placed on obtaining the knowledge and skills required by the area of specialization. The emphasis on the field of specialization is also true of the programs for advanced degrees in nursing. The nurse obtaining a master's degree, in a clinical area such as medical-surgical nursing, assumes the title of clinical-specialist and is the candidate of choice to fill vacancies on nursing program faculties. The result is a paradox: while she may be a master of her subject, her educational preparation to teach is usually scant.

The nurse-teacher has replaced the physician, who historically has been the teacher of nurses in the areas of medical science. Following World War II, the physician participated in nurse preparatory programs less and less. By the sixties, he had practically ceased to participate as a faculty member in the basic nursing program. Katherine B. Nuckolls, associate professor and chairman of the pediatric nursing program at Yale University, School of Nursing, writes of this period: "It was felt that nurses qualified for faculty positions should be competent to teach all of the medical content necessary for the practice of nursing." 15 Nuckolls further writes that the National League for Nursing in 1962 objected to the inclusion of physicians as preceptors in a master's program which was seeking accreditation at that time. Nuckolls attributes this position to the effort by nursing to establish itself as a profession in its own right. The emphasis placed on the teacher of nurses to literally teach all aspects of her

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subject was perhaps responsible for the art of teaching being neglected. Yet it is one thing to know; it is quite another to teach.

In Strategies for Teaching Nursing, Rheba deTornyay states that the "function of higher education is not teaching—it is bringing about learning." 16 If this be true, the art of "bringing about learning" ought to be taught in the nurse-faculty preparatory programs. 17

Right III. The right to an interdisciplinary approach in her academic preparation as a teacher of nurses.

Shirley S. Chater, assistant vice-chancellor for academic affairs and professor of nursing at the University of California, San Francisco, quotes Samuel B. Gould, educational administrator and former chancellor of the State University of New York, in her article addressing the need for cooperative graduate education in nursing:

A decade ago Samuel E. Gould urged educators to:
"...survive and grow in strength by intelligent interaction or many of us will ultimately perish separately as our offerings become steadily more inadequate." 18

As science and technology have advanced, the amount of new data becoming available staggers the imagination. It has become virtually impossible for faculty members to be totally learned in their particular specialty. The expanded role of the nurse is just one sample of the changes that


17 The need for changes in the curricula of schools and colleges of nursing is acknowledged by all nurse-educators. Some leaders in the field of nursing education who have addressed this problem are Imogene M. King, Rheba deTornyay, Mildred L. Montag, Esther L. Brown, Martha E. Rogers, and Eleanor Lambertsen, to name a few. The controversy exists between what should change and how it should be changed.

had to be made in the basic nursing programs to meet the changing roles of all the health professionals. The advances in science and technology with its resultant changes in theory and practice, demands that an interdisciplinary approach be used in health education and services.

The interdisciplinary approach to nursing education will allow for true expansion of the nursing profession, one which will be diverse, encourage individual thinking and creativity, and promote the health team approach, rather than the "tunnel-vision" approach which has been the result of lopsided faculty composition. The nursing profession should be secure enough by now to let go of a narrow approach to nursing education. Nurses should teach nursing and guide its course, but there is a place in nursing education for the expertise of other health professionals.

Charles K. Hofling and Madeleine M. Leininger, in their book *Basic Psychiatric Concepts in Nursing*, write that "a...trend emergent in nursing is the close and cooperative working relationships with other members of the health team," and further that "the various groups of personnel have become interdependent."

They conclude that this trend for a cooperative working relationship reflects a need to unify the service of other groups into a relative wholeness for the patient. This need for unification is recognized in nursing education today. Torres, addressing the curriculum implications brought about by the changing role of the professional nurse, writes:

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The identification in the philosophy of the emerging role of the professional nurse will give strong clues as to the general education or supporting courses that students may need. Faculty should look carefully through the entire school catalog for offerings that may be helpful in increasing students' awareness of concepts related to roles. . . . Some examples might include: interdisciplinary health courses. . . .

In support of the need for an interdisciplinary approach to curriculum, Sister Bernadette Armiger, former dean and professor of nursing at Niagara University, College of Nursing, New York, and a past president of the American Association of Colleges of Nursing, writes:

The Dean of the Future will administer her school in a new health care delivery system. In the new system cooperation will be placed above territorial imperatives, and interdisciplinary sharing will extend beyond encounters in the faculty dining room and the university senate. The simple cost benefits of core courses for students in the health professions will force faculty to re-examine the possibilities for multidisciplinary curriculum planning. They will be more willing to create coordinated contractual arrangements for clinical experience for students of nursing, medicine, pharmacy, and allied health disciplines, to institute multidisciplinary team teaching of core courses, and to develop shared clinical experience that will follow Reed's suggestion: "the time and place to learn how to function as a team is in a supervised interdisciplinary clinical and educational setting. We cannot expect the 'health care team' to be effective if the members haven't learned how to work together as students."

The need for interdisciplinary efforts in service to patients and in professional education is emphasized, for example, in the emerging field of bioethics. The report of the Commission on the Teaching of Bioethics, states:

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Bioethics has arisen as an interdisciplinary field, one of the few where cooperation and discourse across the usual boundaries have been both intense and fruitful. . . . no one field has been able to claim a monopoly on the issues, and many fields have simultaneously felt the impact of the problem. 22

The stress on the interdisciplinary approach in health care relate then to both the education of all health professionals, and to services for the patient.

Catherine M. Norris, professor of nursing, University of Kansas Medical Center, offers the following assumptions, in projecting for a meaningful future for the nursing profession:

"1. The delivery of curative and restorative care by professional nurses cannot be effected while nursing is unilaterally defined, programmed, and administered by nonnurses.

"2. On the other hand, nursing cannot expand its role in isolation or unilaterally, even though it can reject or accept assignment of roles by other disciplines.

"3. Collaborative activities with physicians and other professionals must be greatly increased for the purpose of working out roles that would provide major assistance in the preparation of faculty who could teach the expanded nurse roles and for establishing the kind and the quality of relationships with nurse practitioners that would deliver effective care." 23

The reasons for an interdisciplinary approach in the academic preparation of nurse-teachers are (1) the advances in science and technology with its resultant changes in theory and practice, makes it impossible for any one professional to have total knowledge and expertise.


in the discipline; (2) through association with other health disciplines and the sharing of knowledge between disciplines, nursing will be able to expand its role and encourage individual thinking and creativity in its members; and (3) the need to unify the services of all members of the health team into a relative wholeness for the patient.

Right IV. The right to refuse to teach subjects which she is not qualified by academic preparation or experience to teach.

Teachers should not be coerced into teaching subjects that they are not qualified to teach. Often, because the budget may not allow for the necessary number of faculty to be employed, the existing faculty must assume courses that they are not prepared to teach. Maureen S. Fry, Project Director, Foreign Nurse Graduate Program, Boston City Hospital, School of Nursing, in an analysis of the role of the nurse-educator, quotes William J. Goode's theory of role strain. She writes that one type of role strain results because of specific demands made on either time or place. She writes: "...we can appreciate that the nurse-educator at times must feel like a 'one-man band.'"

Many nurse-faculty members are called upon to teach a course in "nursing ethics" or to include ethics in all of their subjects without any preparation in the area of ethics whatsoever. To make matters worse, they may not have the means available, or the administrative backing, to bring in experts in the field. They are often told "to make do." Nursing education programs, for the most part, have not been given economic support or social status within colleges and universities equal

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to what their medical counterparts have. It seems that college and university administrators accept the premise that the education of a doctor is a costly venture. The education of a nurse is looked at as a drain on the budget, and often perhaps as a "pain." Nursing, just as medicine, needs adequate hard- and software teaching supplies. Nursing education also needs to draw upon experts to address their students and to consult with their faculties. They should not get the "leftovers" and be expected to create an educationally sound environment and program.

Justification for proper funding can be based on the expanded role of the nurse in contemporary health care. Some economic problems can be solved through the development of the core curriculum. The basic problem of economic support remains. The impact on nursing education by such suggested legislation as the National Health Insurance programs is great. While the economics of nursing education is not in the realm of this paper, it is a vital factor in the nursing education picture.

That the nurse-teacher should not teach a subject for which she is not prepared is supported in Principle IV of the Code of Ethics of the Education Profession (see Appendix B). In this section, the code states: "the educator. . .shall apply for, accept, offer, or assign a position or responsibility on the basis of professional preparation and legal qualification."

25For data relating to the costs of medical and nursing education, the reader is referred to the American Hospital Association, the American Medical Association, the American Nurses' Association, and the National League for Nursing.

26Articles concerned with National Health Insurance and its implications for nursing are available in the National League for Nursing's publication Challenge to Nursing Education. . .Professional Nursing Practice and is available through that organization.
Right V. The right to programs designed to prepare her in the area of teaching critical life issues.

It is generally agreed that it is the nurse who spends the most time with the patient (in the clinical area at least). During this time, she is often called upon to counsel or advise a patient (client) in a life situation which may be a common or ordinary one, or in an uncommon extraordinary one, a critical life issue. A nurse, realizing that she is unprepared to handle a problem which is out of the ordinary, may seek some sort of program which will help her develop skills in helping patients cope with these extraordinary problems or "critical life issues." The nurse will have great difficulty finding a nursing program which will help her to develop these necessary skills. Programs are not readily available in the area of medical-moral problems and nursing per se.

Nursing is not alone in this need for educational programs in medical-moral problems. Medicine is itself just making inroads in preparing its own practitioners in this area. Nursing has very few opportunities available. Supporting this statement is the report of the Commission on the Teaching of Bioethics from the Hastings Center, Institute of Society, Ethics and the Life Sciences. The report states:

While nursing schools show a tremendous amount of interest in ethical questions, the evolution of formal courses and programs of ethics teaching seems to be less developed than in undergraduate and medical schools.

...There are to our knowledge no instructors in nursing schools with a title of "professor of ethics" or its equivalent. There are no formal "programs in ethics." There are few opportunities for nursing students to take elective courses. ... Most people teaching
ethics in nursing schools are currently doing so as a secondary activity. . . . 27

Regardless of this apparent poor status report, some progress is being made. In 1976, the Joseph P. Kennedy, Jr. Foundation, 28 awarded five nursing faculty fellowships in medical ethics. The Fellowships provide grants up to $18,000 per year for "study and research involving the ethical, religious, philosophical and legal implications of medical decision-making particularly in problems related to mental retardation. This is the first time that the medical ethics fellowships have been extended to include the nursing profession." 29 While these fellowships are specifically directed to the mental retardation field, they are a landmark in nursing history. Nursing has finally received formal recognition for the role it plays in the ethical, religious, philosophical, and legal considerations involved in medical decision-making.

The Hastings Report includes what is seen as the future needs and priorities of nursing schools:

"1. There is a desperate need for basic literature, curriculum materials, case studies, and audiovisual materials to be developed which are specifically oriented to ethical issues for nurses.

"2. There are virtually no trained teachers with adequate skills in both clinical aspects of nursing and ethics training, opportunities for faculty development must be given especially high priority.

27The Hastings Center, The Teaching of Bioethics, pp. 32-33.

28The Joseph P. Kennedy, Jr. Foundation was established in 1946. Its purpose is to stimulate efforts in the prevention of mental retardation and the care and rehabilitation of those already retarded and to stimulate the investigation of issues related to the vital field of bioethics. More than $50 million has been granted for these purposes.

"3. While workshops and conferences for medical ethics teachers in other teaching settings have existed for several years, there are virtually no such opportunities for nursing ethics instructors. Although conferences and workshops must be seen as preliminary experiences which will lead to more permanent professional communication networks, such gatherings would be valuable for nursing ethics instructors." 30

While the Hastings Report gives a fairly accurate picture of what is happening in the field of nursing education and medical ethics, its priorities for the future of nursing education per se are somewhat nebulous. The Report recognizes the need for teachers, conferences and materials to be developed for nursing specifically. Yet the Institute of Society, Ethics and the Life Sciences does not seem to be concerned enough to offer its support in materials, fellowships or courses.

In summary, in chapter five, A Code of Ethics for the Nurse-Teacher was proposed. It was developed following the pattern of the Code of Ethics of the Education Profession. It outlines the responsibilities of the nurse-teacher. The preamble of the proposed code recognizes the nurse-teacher's commitment to the student, to the patient, to the patient's family, to the physician, to other health professionals, and to the community. From the proposed code are inferred the rights of the nurse-teacher, and a Nurse-Teacher Bill of Rights is proposed. Two needs stressed were the need for prepared nurse-faculty in the area of medical-moral problems, and the need for financial support of the nursing program in ethics. Chapter six, using as its frame of reference critical life issues, will analyze, in that context, the educational preparation of the nurse-educator, what should be taught, and how it should be taught.

30 The Hastings Center, The Teaching of Bioethics, p. 36.
CHAPTER VI

TEACHING BIOETHICS

Thus far, this paper has focused on the following subjects: (1) the definition of critical life issues; (2) an analysis of two life issues: abortion and euthanasia; (3) the definition of modern nursing and the nursing role; and (4) an analysis of the rights and responsibilities of the patient, the nurse, and the nurse-teacher. All four subjects were presented in order to provide the background information needed for consideration of the problem.

The Problem

The problem is: scientific and technological advances in the last few decades have presented ethical dilemmas to nurses as well as physicians. It is not that the health professionals are faced with new problems (for abortion and euthanasia are age-old) but rather the choices for solution are new and often radical. Further, the practice of nursing has changed. The environment of practice and scope of responsibility have changed. The goals of nursing are not limited simply to preserving health, to preventing disease, and to caring for the ill and dying. Nurses are called upon to counsel and instruct their patients (clients) in situations involving ordinary and extraordinary (critical) life issues. Nursing must adapt to technological changes, and it must address itself to the medical-moral problems these technological changes engender.
Chapter one stated the reasons why the problem has developed. These reasons are: (1) new possible ethical and moral choices; (2) a tradition of non-teaching, non-preparation; and (3) a growing consciousness of the nurse's responsibilities. Historically, the education of the health professional has been in the physical and biological sciences—anatomy, physiology, biology, pharmacology, and other associated sciences. The ethical and moral aspects of health education for the health professional have been for the most part neglected. Nursing along with the other health professions has recognized the need for change in the educational content of its program.

Thus far, the ethical considerations of instruction on critical life issues have not been formally taught in the professional schools of nursing. The need for the development of guidelines and curricula in this area is acute and evident. If the nurse is expected to teach and counsel her clients on critical life issues, then the ethical considerations, the rights and obligations of instruction, must be an integral and necessary part of the basic preparation of all nurses.

In preparing the nurse, the teacher of nurses enters into a trust/care relationship with the student and with the patient, thus forming a patient-student-teacher triangle. All three have rights and responsibilities. Chapter six will look at the preparation of the nurse-teacher as a teacher of critical life issues in an educational setting and the ethical considerations of instruction.

**Nature of the Problem**

While there is an abundance of writing and research on the morals involved in the issues themselves (chapter two and three represent a
discussion of only a small sampling of the voluminous amount of articles and books written about abortion and euthanasia), little work has been done in the areas of (a) preparation of the teacher of moral issues or (b) development of curriculum content, design and execution. In the health field, what work has been done in these two areas is in the educational preparation of the physician—and even there it is in its embryonic state. Yet the nurse, because she is "always" there, is more likely to be put into the teacher/counselor role in situations involving life issues and is in desperate need of the educational preparation needed to effectively fulfill this responsibility.

Most nursing educators and administrators agree that the program for the preparation of nurses needs to be re-designed and that educational priorities need to be re-examined. This re-examination and redesign of the nursing program should be done in light of the emergence of bioethics and the corresponding effect it has had in the field of nursing education and practice. Studies have been published which support the need for curriculum change. There are also some nurse educators

1Robert M. Veatch and Sharmon Sollitto, "Medical Ethics Teaching" Journal of the American Medical Association 235 (March 1976): 1030-1033. Veatch and Sollitto conducted a national survey which studied the teaching of ethics in medical schools. One hundred seven medical schools participated. Ninety-seven schools indicated some kind of medical ethics teaching. This included nineteen schools where teaching consisted only of discussion of ethical issues in courses not primarily identified as ethics courses.

2Brown, Thompson, Bulger and Lays published a study in the American Journal of Nursing (July 1971) which reported how nurses felt about euthanasia and abortion. The May 1975 issue of Nursing Update devoted the entire issue to the nursing expertise that is needed in the area of abortion. At the American Nurses' Association convention in 1974, many major papers addressed the need for change in the preparation of the nurse. These papers are published by the ANA in ANA Clinical Sessions 1974 (New York: Appleton-Century-Crofts), 1975.
and administrators who dispute the need for a massive change in the nurse preparation program, among these is Ardis Danon, assistant administrator, Park-med Clinic, New York. The need for the teaching of ethics to nurses is taken up in the Report of the Commission on the Teaching of Bioethics published by the Hastings Center. This commission wrote:

Nurses must be able to take a moral position in a logically consistent manner congruent with more than a nodding acquaintance with ethics. Especially with the increased questioning of the nurse's role vis-a-vis the physician's, problems of power, authority, and conflict resolution, which have ethical implications, must be addressed.

If the preparation of the nurse and the nurse-teacher needs to be studied and revised, then the curriculum content, design, and execution must likewise be studied, revised, and in some instances, initiated.

The solution to the problem will be approached from two aspects: the graduate preparation of the nurse-teacher, and the ethical considerations of instruction.

**Graduate Preparation of the Nurse-Teacher**

**Recommendation I**

The nurse preparing for a career in nursing education, must be intellectually and personally suited to the nature of graduate work. Loyola University of Chicago describes the nature of graduate work in the school bulletin:

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4The Hastings Center, The Teaching of Bioethics, p. 33.
Graduate students should realize that the nature of graduate work requires more than merely acquiring credits with a prescribed grade. They are expected to work independently and to think critically, motivated by their own intellectual curiosity and love of knowledge. They should be capable of original research and independent criticism. It is essential that the graduate student should have the ability, courage and ingenuity to attack his problems independently. 5

Katherine Nuckolls writes that in the early history of nursing education, nurses had been "trained to be rote 'doers' rather than thinking observers, listeners, and responders." 6 That this concept of the nurse has changed is attested to by Daphne Walker Mesolella, Senior Instructor, Douglas Hospital, Verdun, Quebec, who writes "clearly, our responsibility as educators is to free our students' potential for providing creative, concerned, nursing care..." 7

Eric Baker, Head of the Department of Social Sciences, North East London Polytechnic, adds a new dimension to creative care: maturity. He writes that the object in teaching ethics to mature students "is principally to teach them how to think about something in which they are already, so to speak, experienced practitioners." And further "... the maturity of the nurses is invaluable." 8 The nurse preparing herself to be a teacher of nurses, comes to the graduate program with experience that can be used to develop her expertise in problem solving and decision-making.


6Nuckolls, "Who Decides What the Nurse Can Do?," p. 627.


Therefore, the first recommendation of this chapter:

The preparation of the nurse-educator be in an environment which is conducive to learning and which promotes dynamic solid thinking. Courses in the scientific method, problem-solving, the nursing process, and decision-making must be a vital, integral part of the student's program.

Recommendation II

In the expanded role of the nurse, her influence on the decision-making process of the patient can be great. The weight she attaches to her own values may influence the weight attached to personal values by the patient and his family. Marie Czmowski, writing in *Nursing Forum*, addresses the question of value teaching in nursing education. People have varying values and lifestyles, and if the nurse is to help them meet their health needs, nursing educators must "assist students in the clarification of their own values in preparation for nursing practice in a society undergoing rapid change and plagued by value crises."9 Czmowski accuses education of not developing the whole person, and states:

... at the promptings of our technological and industrialized society [education] has centered its attention on the learner's development within the cognitive and psychomotor domains. ... value development and character formation are not really accepted as a primary aim of formal education. 10

The vital role played by the individual nurse's values and attitudes in critical life issues is exemplified in many studies. One such study conducted by Rosen, Werley, Ager and Shea studied the attitudes of three groups of health professionals: medicine, social work, and nursing.

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10Ibid., pp. 193-194.
They compared the professional's attitudes with those of the population as a whole, examined the differences in attitudes among the professions and between faculty and students. Among their findings in the area of abortion were:

Over-all, health professionals favored abortion under certain conditions, particularly in order to protect the health of the mother. . . . Also, more than two-thirds of each professional category would help a client obtain a legal abortion under some circumstances, and more than half of the Catholic professionals in each occupational group, with the exception of nursing faculty, would do so. . . .

. . . Nursing was the professional group least favorable toward abortion, reflecting both a different kind of professional involvement in problem pregnancy than that of social workers and a generally conventional orientation. The occupational socialization of nurses stresses the miracle of conception of life and the importance of preserving it more than the quality of life; it is also within a less scientific, detached frame of reference than medicine.

. . . a related finding is the discrepancy between Catholic students and faculty in attitudes toward abortion. Catholic students tended to be more favorable than did Catholic faculty, in each of the health fields. Since the pattern did not hold for Protestant students and faculty, educational status or age per se are not relevant. . . .

The above study clearly demonstrates that the values held by those caring for a patient in a time of crisis may have a profound effect on the decision-making process of the patient. The beliefs held by the health teacher or counselor may affect the information given to the person seeking help or the content of the educational program being taught. Georgia Kinnamon Adams observes that:

It is a sad commentary on the health profession that they have become so engrained with their own philosophies that they cannot relate to individuals who are making choices about the quality of their lives and that the health professions are ritualistically and perhaps blindly concerned with the quantity of life. 12


Fitzpatrick, Reader and Mastroianni write that the nurse must recognize that the attitudes towards such issues as abortion are extremely varied and personal, and that there are strong religious and moral influences in these attitudes. The nurse is entitled to her own conclusions in the matter and should respect those of others.\textsuperscript{13}

The attitudes of the nurse facing life issues daily may also be affected. Danon, in her study of the nurse and abortion, found that the nurse caring for the patient who had a painful abortion lost her empathetic attitude and as a means of emotional self-defense became distant and cold to the patient.\textsuperscript{14} It appeared from Danon's study that the nurse preferred to care for an abortion patient in a situation that did not involve a close relationship.

Therefore, the second recommendation of this chapter:

The preparation of the nurse-educator include, as a vital integral part of the student's program, courses which help the student to become aware of and be able to analyze her own philosophy of life, her values and attitudes and their effect on the decisions and actions of others (students, patients, families). Courses in the fields of the humanities, the social sciences, and the behavioral sciences must be well represented in the student's educational program.

**Recommendation III**

As stated in the problem, the emergence of bioethics and the rapid advances in the fields of science and technology have added new choices, and often radical choices, to people seeking a solution to critical life issues. The patient seeks help from the health professional. The health professional, for the most part, has not been prepared to meet

\textsuperscript{13}Fitzpatrick, *Maternity Nursing*, p. 460.

\textsuperscript{14}Danon, "Abortion," p. 63.
this need of the patient. George J. Annas, in an article on human rights, quotes Dr. Eric J. Cassell of Mount Sinai School of Medicine, "guidance and experience are considered necessary in making difficult clinical decisions, but in these decisions (involving life and death) —the most difficult of all—most of us have had little guidance and training." 15 The nursing profession, involved closely with the patient and family, at a time they are confronted with a critical life issue, such as abortion or euthanasia, has the least-prepared faculty for teaching life issues. As quoted in chapter five, 16 the Hastings Report on The Teaching of Bioethics, reports that formal courses and programs of ethics teaching seems to be less developed in the nursing schools than in undergraduate and medical schools. The report further states that "what we have not found is the degree of specialization in ethics teaching that has emerged over the past five years in other educational institutions." 17

Therefore, the third recommendation of this chapter:

The preparation of the nurse-educator, should include in the form program, courses in ethics. These courses should be mandatory and be designed primarily to meet the needs of the nurse-educator.

**Recommendation IV**

The rapid acceleration of knowledge and technology has turned the thrust of nursing education towards courses and programs that deal with the more technical and scientific hard-data aspects of patient care.

16 Footnote 27.
17 The Hastings Center, The Teaching of Bioethics, p. 32.
But with new abilities to prolong life (resuscitation, "heroic" measures, and so forth), to end life (suction abortion, saline injection abortion), to change life (transplants, genetics), comes corresponding problems in the social and mental (emotional) aspects of patient care. The field of general education pursued this same course of scientific acceleration, and inherited corresponding problems. John F. Cogswell, in Issues in American Education, looks at the role of the school with regard to these rapid advances in science and technology:

... the tendency to equate machines and people as resources may have dangerous consequences; the desire for control and efficiency attracts the researcher to the machine and tends to ignore the human teacher and the attitudes, feelings, and inclinations of the student. ... if the word humanistic is to have real meaning in our work with the schools, procedures must be developed that put and keep the human being central in the system. 18

In an article, "Symbiosis: Science and Man," the Most Reverend Mark J. Hurley, ordinary of the Diocese of Santa Rosa, California, writes:

The science fiction novel, Fail-Safe, states the issue well. Man, it tells us, feels helpless in an autonomous, technical society. Initially, he seeks relief from drudgery and the slavery of hard and monotonous labor through technology and mechanical devices; then he seeks relief from the drudgery and slavery to the very machines invented to liberate him. Moreover, he feels helpless as the all-powerful state, armed by science and technology, breeds impersonal monsters that know how to control and how to destroy, but not how to liberate and cure. 19

The problems ensuing from scientific and technological advances then are real and people are faced with new and often radical solutions to these problems. Many of these problems are in the health field.


Nursing education has not adequately nor forcefully enough addressed itself to these problems. Nurses are being confronted with these problems every day in their practice. Nurse educators, every day, are involved with students who are seeking ways to help their patients in situations involving critical life issues. Counseling and guidance techniques have been neglected. We have learned how to prolong, end, and change life, but not how to help cope with the effects of this new knowledge.

Salvador E. Luria, in a lecture presented at the Roche Anniversary Symposium in Switzerland in 1972, stated that:

For the time being, scientists have not yet succeeded in formulating a program of constructive contribution to the decision-making process and have limited themselves by and large to proclaiming the benefits of science, disclaiming responsibility for its occasional misuses, and upholding the pre-eminent demands of the progress of knowledge--each of these claims based on convenient, but challengeable values. 20

Therefore, the fourth recommendation of this chapter:

The preparation of the nurse-educator must include courses in the areas of counseling and guidance. This preparation to consist of theory and practice in the clinical setting--hospital, home, clinic, work.

Recommendation V

The health professions, in order to prepare their students to cope with the problems resulting from the advances of science and technology, need to develop their own teachers (physician and nurse educators) in the field of medical-moral problems. In nursing, to prepare the nurse

The educator, the graduate school faculty must, in the near future, look to the development of the "professor of ethics" as mentioned in the Hastings Report on The Teaching of Bioethics. This person would have the responsibility to determine the objectives and curriculum content for the student in the areas of medical-moral problems. She would be the coordinator, planner and developer for the entire ethics program and would be responsible for the integration of ethics into the curriculum. The development of nursing ethics departments would emphasize and give priority to the teaching of critical life issues and put an end to the secondary treatment given to nursing ethics in the nursing education program of today.

Therefore, the fifth recommendation of this chapter:

The position of "professor of ethics" or its counterpart be established and provided for on all nursing school faculties of graduate education.

In summary, the program for the graduate preparation of the nurse-teacher was considered and five recommendations were made. The recommendations were made in a frame of reference which encompasses the nurse-teacher as a teacher of critical life issues. The ethical considerations of instruction in these issues follow.

**Ethical Considerations of Teaching Critical Life Issues**

The ethical considerations of teaching critical life issues encompasses three main areas: the teacher; the program; and the process. The questions to be answered are "Who shall teach ethics in the health professional schools?" "How shall ethics be integrated into the program of the student health professional?" and lastly, "How shall controversial issues be taught?"
The Teacher

The first consideration in the teaching of critical life issues is: Who shall teach them? The need for prepared teachers, nurses and others in the area of bioethics is evident. The Hastings Report answers the question "Who should teach bioethics courses?" with an answer that offers a permanent solution as well as a temporary one:

However the course bioethics is taught, the teaching staff must have competence in both ethics and the biomedical sciences. An ideal teacher would have professional competence in both ethics and biology or medicine nursing. But the problems inherent in such highly specialized dual training, combined with the probable difficulty of maintaining full professional standing either as an ethicist or as a scientist/clinician, make such a teacher unusual. An alternative is for teachers to be competent professionals in one area with "competent amateur" standing in the other. 21

The above solutions are directed by the report to medical schools but they can, just as easily, be directed to nursing schools. The "competent amateur" is a temporary measure. For a permanent solution, nursing must develop a program which will produce a "professor of ethics" or its equivalent. This task of educating a "professor of ethics" may be a difficult one to achieve unless such major teaching institutions as the Kennedy Foundation and the Hastings Center offer educational opportunities for such a person to be developed. In the Hastings Report, they write: "At least one such program [nursing bioethics] should be established, probably through a graduate level program in medical ethics which has already organized similar general clinical training." 22 While the Report supports such a program, the Hastings Center does not offer to provide such an experience nor even hints at it.

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21 The Hastings Center, The Teaching of Bioethics, p. 11.
22 Ibid., p. 36.
The Report does offer yet another temporary solution to the problem arising from the need for prepared teachers of bioethics in nursing:

Faculty members, individually and collectively, should be competent in both the clinical aspects of nursing and the discipline of ethics. Since virtually no nursing instructors have professional competence in both simultaneously, team teaching should be the norm for the foreseeable future. 23

On a large scale, the only approach that is feasible today is the team approach to the teaching of bioethics in nursing. The team approach though should only be a temporary measure to be utilized while faculty are prepared to assume this responsibility. Nursing colleges and schools of nursing need to actively pursue the attainment of these educational experiences for designated faculty members. Once a faculty member becomes qualified as a "competent amateur," she can plan, coordinate, and integrate ethics into the appropriate sections of the nursing curriculum. Further she could help to develop other nursing faculty members in the teaching of ethics as related to their particular specialty.

Finally, the Report in its analysis of the future needs and priorities for the teaching of bioethics in nursing states that opportunities for faculty development must be given "especially high priority." Thus far in this paper, the need for preparation of nursing faculty in this area has been made evident. In the preceding section of this chapter, recommendations were made for the graduate preparation of the teacher of nurses and these recommendations are in agreement with the findings of the Hastings Report. The Report demonstrates the

23 Ibid., p. 35.
desperate need for opportunities by nursing faculty by stating: "the one fellowship program designed specifically to train nurses in ethics had 200 applicants for two fellowships. There are no organized opportunities for ethics instructors who teach nursing students to get clinical exposure from a nurse's perspective." 24

The Program

The second consideration in teaching critical life issues is in the program structure. How shall ethics be integrated into the program of the student health professional? As isolated courses? Integrated into many courses? A formal part of the program? An elective? Veatch and Sellitto in their national survey of medical schools, reported the following: of the 107 schools that responded, 97 indicated some kind of medical ethics teaching. In 19 of these 97 schools, the teaching consisted of discussion only of ethical issues in courses not primarily identified as ethics courses. There is, as this survey demonstrates, a need to formalize the basic content of all programs of bioethics in medical schools, nursing schools, and other health professional schools.

Veatch and Gaylin, in an earlier article, support the need for a systematic approach to the study of medical ethics:

...it is apparent that, especially in this period when the biomedical revolution is changing medical practice so rapidly, there is a need for giving the systematic study of the social and ethical aspects of medicine a central place in the medical school curriculum. 25

24 Ibid., p. 36.

25 Veatch and Gaylin, "Teaching Medical Ethics," p. 780.
The preparation of the physician in bioethics is a concern of the nurse, since it is usually the nurse who carries out the instructions of the physician. There is an increasing incidence of medical-moral disagreements among physicians and nurses. There is a need for formal programming in both medical schools and nursing schools. Further, there is an even greater need for the establishment of formal programs involving both these disciplines.

Does a systematic approach to the study of medical ethics entail that ethics courses should be isolated throughout the student's entire program? Howard Brody and co-authors endorse the integrated approach:

A good first step toward emphasizing the importance of ethical decision-making is to structure the ethics teaching throughout the four years of medical school. Integration...depends upon matching the content of each portion of the ethics program to the content being dealt with in other courses at that point. The rationale for the integrated approach is: This approach would ensure the proper planning, coordinating, and executing of the program and curb the practice of using ethics courses as curriculum fillers, and it would offer a broader knowledge base with planned exposure by the student to a variety of medical-moral problems and their possible solutions.

26 The Hastings Center, The Teaching of Bioethics, p. 33.

27 One such joint program was formed in London. This group, called the London Medical Group, was established because of the urgency felt by physicians and nurses involved in medical-ethical problems which were being confronted almost on a daily basis. For further information concerning this group, the reader is referred to an article "The London Medical Group," by Sue Pace in Nursing Times 65 (May 1969): 610.

28 Howard Brody et al., "Integrating Ethics in Medical Curriculum," p. 112.
The program structure for the teaching of bioethics as endorsed in this paper is a combination of the isolated and integrated approaches to the teaching of bioethics. The combination of approaches would ensure that all the health professions have a core base of knowledge in bioethics. From the core base, programs could be developed which meet the specific needs of the individual professions. The program structure recommended is:

1. A basic core content of bioethics should be developed which is specific to and appropriate for medical schools, nursing schools, and other health professional schools.

2. Bioethics should be integrated throughout the educational programs of all the health professional schools. Curriculum design should match the content of the bioethics program with other courses and clinical experiences.

3. In areas of mutual interest and concern, joint programming for physicians and nurses should be developed.

The Process

The third consideration of teaching critical life issues is the process. How shall controversial issues be taught? Search of the literature in the field of general education indicates that present discussions are limited to the study of the opinions of educators in how controversial issues should be treated or "handled;" the factors which condition the presentation and discussion of controversial issues; and the proper role of the teacher with reference to the use of controversy.

The following dissertations are examples of the studies conducted in the area of teaching controversial issues: "Opinions of Virginia Schoolmen Concerning the Treatment of Controversial Issues," by Calvin W. Deam, Indiana University, 1957; "A Study of the Handling of Controversial Issues in Social Studies Classes of Selected High Schools in Georgia," by Thelma Thompson Kirby, Auburn University, 1964; and "An Inquiry Into the Proper Role of the Social Studies Teacher With Reference to the Use of Controversy," by John Paul Lunstrum, Indiana University, 1960.
Almost all dissertations in the education field use social studies classes as their area of study. If in general education the study of how to teach controversial issues is limited, in the health education field it is almost non-existent. Only one dissertation was found but it was only remotely connected to the teaching of controversial issues.

One small but excellent book, The Teaching of Controversial Subjects by Edward L. Thorndike, offers an answer to the question, "How shall these issues be taught?" Thorndike proposes two theses: the first, the teaching of controversial subjects can be best accomplished by using only demonstrable truth (or in modern terms, "hard-data"); and the second, all such issues are to be discussed freely, fairly, and usefully even when they are not supported by scientific fact.31

If the first thesis is followed, that of teaching controversial subjects based solely on demonstrable truth, what should the educator be cognizant of? First, that as facts and principles of science dealing with the consequences of events and acts are discovered, they will provide intelligent and thoughtful persons with the best preparation, per unit of time spent, that schooling can give. Thorndike called this method a science of values; second, that the one limitation of using demonstrable truth only is, according to Thorndike, that it will be relatively inert and sterile educationally if it "fails to tell what ought to be done, what is good, useful, fine, humane."32


32Ibid.
asks whether it is possible to have sciences of welfare, duty, justice and the like comparable to the sciences of mass, motion, chemical change, and physiological function? He answers:

We certainly can have sciences which try to discover the consequences of acts and events to the satisfaction of the wants of men; and these will, as they develop, provide principles which every sane religion and every unselfish moral code will heed. 33

If the second thesis is followed, that of teaching controversial subjects freely, fairly, and usefully regardless of the absence of scientific fact, what should the educator be cognizant of? First, he should make sure that every such controversy is made the occasion to learn, renew, or apply fundamental facts and principles; second, he should distinguish carefully those controversial questions which people should try to answer for themselves from those which they should be taught to refer to experts; third, he should use primarily the methods of science rather than those of emotion, discussion, and persuasion. This second thesis is therefore based on the use of knowledge available (hard-data) and the application of this knowledge whenever and wherever possible. The second thesis also stresses the need for the teaching of: (1) the weighting of values, (2) the establishing of priorities, and (3) the decision-making process to students.

In situations where the knowledge of the person is limited or unattainable, the use of experts is advised. Thorndike offers the following rule:

The rule is general. When we lack the necessary knowledge and some impartial expert has it, the right answer in any controversy is, "Ask the expert."

33 Ibid.
With the progress of science, technology, and business, the matters in which public opinion, even though alert and enlightened, is incompetent become more and more numerous in comparison with those in which it can be competent. 34

A key element of this approach therefore is the necessity of experts in bioethics. Are experts available and in the numbers necessary? Howard Brody answers:

A survey conducted by the Institute of Society, Ethics, and the Life Sciences has shown that there are presently only a handful of individuals in this country with formal training in both medicine and ethics. 35

Since medicine and nursing do not have the needed experts, in preparation or numbers, then the team approach mentioned earlier appears to be the interim answer.

Thorndike, in his second thesis, discards the use of emotion, discussion, and persuasion. He places emphasis on the use of the scientific method. This writer agrees with Thorndike that emotion, discussion, and persuasion should not be employed when teaching controversial subjects. One small point needs some clarification: that is, what did Thorndike mean by discussion? If he meant that discussion is limited to "idle" talk about an issue without hard-data as a basis, then it is unacceptable as a method to be used in the teaching of controversial issues. To discuss, to this writer, means to analyze the hard-data available, to list the pros and cons of the question, and to assess the solutions available. In this context, discussion is an acceptable method to be employed when teaching controversial issues. Discussion will be employed in the teaching model presented later in

34 Ibid., p. 18.

Emotion and persuasion can be used to present an issue in a biased fashion. The importance of an unbiased presentation to students as well as to patients seeking advice in controversial issues cannot be overstated. As noted earlier in this paper, the nurse and physician can affect the decisions made by a patient and his family. The feelings and attitudes of the health professional affect the patient. In chapter five, in the "Proposed Nurse-Teacher Bill of Rights," the first right was the right of the nurse-teacher to know herself, her capabilities, her assets, her liabilities, her values, her philosophy. This right of self-knowledge and awareness seems so basic that it is often overlooked or taken for granted. Yet to recognize one's own influence on others is precisely what Thorndike is trying to emphasize when he cautions the educator to avoid using emotion and persuasion when teaching.

How does one teach without letting emotion cloud the issue? According to Thorndike it is not an impossible hope that impartial observations and experimentation may achieve this ideal of teaching without the clouding of the issue by emotion and non-scientific methods. But he cautions that impartial observation and experimentation are methods not easily available in controversial subjects. Thorndike offers two other "powerful and flexible" methods that can be used: a quantitative treatment of probabilities and an attachment of weights to facts and opinions.

The quantitative treatment of probabilities is applied thusly: on one side of a controversy are listed the "pro" facts; on the other side are the "con" facts. The mere inspection of these facts may show
any impartial thinker that one is more probable than the other. Action
is then based upon that conclusion. The same holds good if the facts
are more nearly balanced on both the pro and con side. The probability
given to pro by each item separately and by all together may be esti-
mated or computed and then compared with that given to the con facts.
In some cases both pro and con may negate each other and some alterna-
tive "alt" may be given a higher probability than either pro or con.

A score of controversies treated in this manner will probably in-
clude one in which a large number of pros, each of which is of little
consequence, which are independent, but together may produce a very
high probability. "Emotionally they would be at a great discount in
comparison with one or two vivid and moving Cons,"36 writes Thorndike.
Thorndike elaborates:

.. .schools should lead pupils to weigh evidence not be moved by
it.

.. .in every case a deliberate orderly treatment, measuring and
computing when we can, estimating when we must, getting finally
probabilities which themselves are only probable, will be far
better than a non-quantitative rhetorical presentation of the facts
which leaves the mind to guess at the answer, or, worse still, pre-
judices it unfairly. So I comment to you most heartily as an edu-
cational treatment of controversial subjects, the replacement of
discussion and persuasion by statements of relevant facts, and of
the probabilities which may be derived from these facts. ... 37

Can this method of quantitative treatment of probabilities as sug-
gested by Thorndike be applied to critical life issues? Can these is-
sues be categorized into "pro" statements, "con" statements, and "al-
ternatives" as Thorndike suggests in his treatment of controversial


37Ibid., pp. 27-28.
subjects? Issues such as abortion and euthanasia could be approached in such a manner. A teacher could list, as she sees them, the pros and cons of the abortion issue. She could list the alternatives to abortion. The difficult task would be the attachment of weights to these opinions and facts. While this method may at first appear to be cumbersome and perhaps impossible to apply in the teaching of critical life issues, it does have merit if only because it would cause the teacher to carefully analyze the problem. This method would also force the educator to clearly define the issue.

How then shall bioethics be taught? Bioethics should be taught by using a combination of the methods suggested by Thorndike: first, using demonstrable truth whenever possible; second, using an open approach freely, fairly, and usefully; third, using the method of quantitative treatment of probabilities; and fourth, weighting of values. This combination of methods would be as scientifically founded as possible and would avoid the clouding of the issues by emotion, discussion, and persuasion. Such a method is endorsed by Eric J. Cassell, clinical professor of Public Health at Cornell. Cassell writes that some standards or guides to measurement are necessary in order that "we might get down to the daily business of making the decisions rather than constantly discussing how the decisions are to be made."38 Is not the "daily business of making the decisions" what the teaching of bioethics is all about in the clinical setting?

How then shall bioethics be taught? Freely, fairly and usefully. In the introduction in chapter one, it was stated that this paper focuses on ethics in daily practice, ethics on a one-to-one relationship, and ethics in the here and now where issues need to be resolved. Medical-moral issues need to be approached openly and with all the legal, theological, sociological, and psychological data available.

In summary, this chapter stated the problem of teaching controversial issues in a nursing school or college and reviewed the nature of the problem. The solution to the problem was approached from two aspects: the graduate preparation of the nurse-teacher and the ethical considerations of instruction. Five recommendations were made for the graduate preparation of the nurse-teacher. The ethical considerations of instruction analyzed three main points: the teacher, the program, and the process. Chapter seven will offer a model for the teaching of a critical life issue with an example of a simulated case.
CHAPTER VII

A TEACHING MODEL AND CASE STUDY

Chapter six analyzed the ethical considerations of instruction and offered five recommendations for the graduate preparation of the nurse-educator. Chapter seven offers a teaching model designed for use by a "prepared" nurse-educator. The teaching model is constructed with the recommendations made in the preceding chapter in mind. A case study is offered at the conclusion of the chapter.

A Teaching Model for Abortion

This teaching model is designed for the nurse-teacher, who is academically prepared to teach critical life issues as a "competent amateur." The curriculum content is based on but not limited to inclusion of all demonstrable data available. The educational climate should be one of openness—the issue to be presented freely, fairly, and usefully.

The Instructor(s): A nurse-teacher should be the person primarily responsible for program design and content. She coordinates other members of the health professions in a team approach to the teaching of the issue.

The Format: The curriculum content is divided into two sections:
(1) demonstrable truth or scientific data
(2) points for discussion (items which are not necessarily supported by scientific fact or hard-data).

Curriculum Content: Items one (1) through four (4) are either standard acceptable definitions or scientific fact, in other words, "demonstrable." Items five (5) and beyond are points for discussion.

1. Defining the Issue

Basically, any interruption of a pregnancy before viability is called abortion, regardless of cause. Interruption of pregnancy after viability is delivery, whether the infant is alive or dead, immature, premature, or full-term. Viability is defined as the ability of the fetus to survive outside the uterus.

2. Subclassifications of Abortion

Abortions are spontaneous or induced. Spontaneous abortions occur as a result of stressors within the homeodynamic systems. Induced abortions occur directly as a result of mechanical or medicinal agents. Induced abortions can either be legal or criminal.

3. Methods of Inducing Abortion

Up to the twelfth week of pregnancy, usually one of two methods is used: (1) suction; and (2) dilatation and curettage (D&C). Both procedures are performed under a general anesthetic. A third method of inducing abortion is the use of a saline solution which is administered into the uterine cavity through the abdominal wall. Saline stimulates the uterus to contract, and thus to expel the products of conception. The mother is awake during this procedure
and the entire procedure (from injection to expulsion) takes approximately 32-48 hours.

4. Sociological Aspects of Abortion

The legal, religious and moral aspects of abortion are part of the sociological aspect of abortion. There are many sociological trends, some of which are: (1) the "Abortion Culture;" (2) women's liberation; (3) population control; (4) economics and abortion; (5) social pressures; (6) the legal status of the fetus; and (7) public and professional educational sources.

4.1 Legal Aspects of Abortion

On January 22, 1973, the United States Supreme Court rendered a historic decision on abortion (Doe v. Bolton, Roe v. Wade): the legalization of abortion. Abortion on request is allowed under this law. On July 1, 1976, the United States Supreme Court expanded the parameters of permissive abortion. The main decision rendered was that spousal consent and parental consent (for minors) are not necessary for an abortion to be performed.

4.2 Religious and Moral Aspects of Abortion

Organized religion is far from agreement on the abortion issue. At one pole is the Catholic Church position, which is clearly against abortion, and at the other pole, the Jewish position which, in its laws, does not mention abortion as a crime. Somewhere and everywhere on a broad spectrum of opinion lie the Protestant positions.
The following are points for discussion:

5. Defining abortion presents little if any problem to the patient or the nurse. Emotional and psychological sequelae are evident in patients and nurses and are in need of discussion.

The Patient:

5.1 Does the method or week of abortion have any emotional or psychological sequelae?

5.11 There may be substantial psychological sequelae associated with late pregnancy termination. One study (Bracken and Swigar) suggests that this may result from the trauma of the saline infusion itself and the removal of an active fetus which has already become the object of some psychological investment.

5.12 Up to the twelfth week of pregnancy, the reality of the pregnancy itself is often vague and there is no sense of a baby. Thus, the mother has to deal with the feelings of loss of the state of pregnancy rather than loss of a baby.

5.13 Depending on the stressors that caused the mother to decide to terminate the pregnancy, the mother may be able to adapt more effectively to those stressors now that the crisis state of pregnancy is over. On the other hand, there is a possibility that the termination of a pregnancy may add to the stressors due to feelings of guilt, and so forth.

The Nurse:

5.2 What is the role of the nurse as counselor and teacher and can she in this role affect the patient? Is the nurse affected?
5.21 During the time that the mother is in the hospital for an abortion, she does not like to be left alone. The mother finds it helpful to talk about her decision and about her future plans in an accepting atmosphere. The nurse is often placed in the position of counselor and teacher.

5.22 The philosophy, values, and beliefs of the nurse can affect the patient and her decision drastically. The influence of the nurse is not restricted to the hospital setting. In many clinics nurses are involved in giving preabortion and postabortion counseling. In these sessions the nurse helps the mother to clarify her thinking and reasoning so that her decision about the abortion is as rational as possible. Many nursing researchers, Danon for example, report that the nurse may crucially affect the life of a woman who finds herself in a hapless situation. The nurse's own feelings and attitudes are of great importance.

5.23 The Danon study revealed that the nurse caring for a patient who had a painful abortion lost her empathetic attitude and as a means of emotional self-defense became distant and cold to the patient. It appeared from the Danon study that the nurses preferred to care for abortion patients in situations that did not involve close relationships.
6. From a legal point of view, any discussion of abortion revolves around four different foci: the fetus itself, the pregnant woman, the family into which the expected child will be born, and the surrounding community. The conflict centers on the rights of the mother versus the rights of the fetus.

6.1 What are the legal interpretations of the rights of the fetus? Of the mother?

6.11 Under the Constitution, the fetus has no legal right to life according to the interpretation of many lawyers. The Court asserts that the fetus is not protected by constitutional guarantees. Yet others contend that while the unborn's right to life is not explicit in the Constitution, still, unlike the right to abort, it is recognized by law, custom, and majority opinion and could easily be inferred from the Declaration of Independence. There it is stated that "all men are created equal and endowed with inalienable rights." Creation is traditionally associated with conception.

6.12 The ruling of the Court is rooted in the view that the right to privacy of the mother is an indivisible part of every American's "liberty," and is specifically protected by the due-process clause of the Fourteenth Amendment.

6.2 What are the main arguments put forth by supporters of abortion-on-demand (proabortionists)?

6.21 It is the right of the woman to make her own decisions.
6.22 The fetus is not considered a person or a human being.

6.221 Proabortionists have not addressed the issues of
the right of the unborn to life or to the ques-
tion of: When does a fertilized egg (zygote)
become a human? They do not address these is-
issues because they do not recognize them.

6.23 Laws that abrogate a woman's right to safely terminate
her pregnancy are regarded as sexist. Consents and
opinions of others (physicians, spouse, parent) there-
fore are not necessary.

6.3 What are the main arguments put forth by antiabortionists
(prolife supporters)?

6.31 The unborn has a right to life.

6.32 The embryo (fetus) is recognized as a "meaningful"
human from the moment of conception.

6.321 Antiabortionists have severely criticized the
Court for its position as to when meaningful
life begins. They accuse the Court of incom-
petence about life and feel that the Court should
have declared the matter nonjusticiable.

6.322 If, in the view of the Court, the fetus is not
a recognized human being, then there is no rea-
son to worry about the health of the fetus.
This would imply that fetal experimentation is
acceptable and questions the government's con-
trols over drugs which may affect the fetus.
6.4 Are there any other views about abortion?

6.41 Many lawyers believe that the abortion issue is a value issue, not a biological one.

6.411 Many prolife supporters state that social convenience and utility are the order of the day and the question is not for some "When does life begin?" It is "When does dignity begin?"

6.412 There are three schools of thought on the question, "When does life begin?" They are:

The Genetic School--human life begins at the moment of conception or at the moment of the fixing of the genetic code.

The Developmental School--some development is necessary before the term human can be applied. At what point in the developmental process the fetus becomes human is still being debated within this school.

The Social Consequences School--human adults, not biological data, decide what is human, and such decisions must take into account the morality that society wants. This school rejects all biological data as determinative.

6.42 Some prolife supporters hold that the decision (1) to abort or not and (2) under what circumstances is a value judgment and therefore is entirely outside the province of medical science. Since such judgments pose essentially moral, not medical, problems, they call for the
judgment of moral, not medical, specialists.

6.43 Many philosophers and theologians believe that the difficulties encountered are not due to the moral problem involved, but rather in the solution of the problem. Some have suggested that new understandings and formulations be devised to meet the challenges that new circumstances present to basic human values. As circumstances change, values may have to be reevaluated and new priorities set. The problem here is one of assigning the appropriate weight to the considerations involved.

7. Crucial points in the religious aspects of abortion are the right to life (of the fetus) and the value of human life.

7.1 What about the questions of ensoulment and the principle of double effect?

7.11 The question of "ensoulment" and the principle of double effect make the problem more complicated. The theological debate revolves around the arbitrary point in fetal development when the fetus becomes a person. The question then is: What is "human?"

8. The legal, religious and moral aspects of abortion are part of the sociological aspect of abortion. There are many sociological trends having implications for abortion.

8.1 What are some of the sociological trends which are important to the abortion issue?
8.11 The Abortion Culture. The abortion culture is related to the question of what is the value of human life? Concern is placed on the creeping utilitarian ethic of the abortion culture believers.

8.12 Women's Liberation. In the context of the abortion issue, women's liberation is concerned basically with the right of women to make their own decisions, to control what happens to their bodies, to be equal. One question raised here is "Has a potential human the right to live inside an actual woman without her consent?" Prolife supporters question the thrust of this movement. Prolife supporters believe that the women's liberation movement should champion the positive rights of woman (one of which is her right to bear children) rather than to frustrate the "very pinnacle of her triumph."

8.13 The Population Explosion. Should abortion be used as a means of birth control to solve the population problem? Would not contraception be the means to control the population growth rather than abortion?

8.14 Reduce Governmental Costs. Termination of pregnancies with genetic defects would, some argue, reduce the costs involved in the care of such children, and ultimately, adults.

8.141 Economists ask can we afford equal health care for all?
Is abortion the answer to social pressures? Can the problems of poverty, poor housing, racism, and illegitimacy be solved by abortion?

The above teaching model is far from complete. As new data becomes available, techniques developed and refined, and new legal, religious and sociological interpretations emerge, the model will have to be updated and changed.

Throughout this paper it has been emphasized that the focus of this thesis is ethics in daily practice, ethics on a one-to-one relationship, and ethics in the here and now where issues need to be resolved. Therefore, it seems logical at this point to present an ethical problem and show how it might be "handled," "cope with," or "deal with" by two nurses: one nurse with biases which are not "controlled," and a second nurse, using the combination of approaches recommended in this paper.

Case Study

Martha, age 15, is a sophomore at a parochial high school. She lives with her parents in a lower-middle income urban community. Martha is two and one-half months (ten weeks) pregnant. She is afraid to tell her parents. She is considering abortion; but does not really want to "kill the baby." She decides to go to an abortion clinic at her community hospital.

The counselors are Nurse A and Nurse B. Nurse A is an agnostic. She supports the women's liberation movement. She is "strongly opinionated" according to her friends. She is described as a pragmatist--she does her duty as she sees it. She believes in abortion because she
does not "want to pay taxes to support children of unwed parents," and she does not believe that the fetus is a human being until birth.

Nurse B is a Protestant. She believes that the fetus is human, although she does not know when in intrauterine life the fetus becomes human. Her friends describe her as a "good listener." She believes in equal rights for women. She is concerned over the recent Supreme Court decision to legalize abortion. Her concern centers on the question "Does the right of the mother to control what happens to her body supercede the right to life of the fetus? She is basically a humanitarian and has strong feelings for people.

How will the nurses counsel Martha? Each nurse will consider the pros, cons, and alternatives of this particular case from her own viewpoint. These pros, cons, and alternatives and the weights Martha attaches to each of them follow. The facts will be weighted:

| Strongly opposes | (-2) |
| Mildly opposes  | (-1) |
| Neutral         | (0)  |
| Mildly in favor | (+1) |
| Strongly in favor | (+2) |

A positive (+) weight indicates a "pro" statement for abortion; a negative (-) weight indicates a "con" statement against abortion. The weights attached to each statement will be added up. If the total score is positive, then an abortion will be the action of choice. If the total score is negative, then abortion will not be the action of choice.
Nurse A discusses the following facts and judgments with Martha:

1. Abortion is the termination of a pregnancy. Since the fetus is not capable of life outside the uterus at ten weeks gestation, it is not human. Therefore there is no problem of killing the baby.

2. The abortion can be performed under a general anesthetic. Therefore Martha will "feel nothing." (Nurse A does not mention any possible psychological sequelae.)

3. Martha's parents do not have to be told about the abortion since their consent is not necessary according to law.

4. Martha's religious concerns are not "practical." Nurse A informs Martha that the church during its history has fluctuated its position on abortion.

5. Economically, Martha cannot afford to support a baby, nor can her parents. Nurse A strongly suggests that Martha's baby would be a "drain" on other people.

6. Nurse A reminds Martha that she is "young and with her life ahead of her." She asks Martha whether she really wants to be "saddled" with a child? She suggests that Martha may want to "develop herself as a person." Having a child would only "get in her way."

Martha's feelings and concerns:

1. To abort means to kill a baby. Martha's "deep-down" or "gut" feeling is not to have an abortion.

2. Martha gives no thought to how abortion is done or to the possible consequences and side effects of this procedure.

3. Martha does not want her parents to know about her pregnancy. Yet she has ambivalent feelings.

4. While not overly religious, Martha feels that abortion is against her religion.

5. Martha cannot afford a baby nor can her parents.

6. Martha has never thought how the baby or an abortion might affect her future.
7. She tells Martha to be "practical" and have an abortion. Nurse A offers no alternatives.

7. Martha has heard of adoption but is unsure of exactly what it would entail. She does not feel she should ask since the nurse has not mentioned it.

The results of the counseling session between Nurse A and Martha are listed in the following pro and con statements with the numerical value (as perceived by Martha) attached.

Statement: Numerical Value:

1. Martha, while somewhat unsure about when the fetus becomes a human, decides to accept what Nurse A has said about "humanness." +1

2. Since there is an absence of pain or after effects as far as Martha knows, she is in favor of the procedure, regardless of the method used. +2

3. Martha does not want her parents to know about her pregnancy. +2

4. Economically, Martha cannot support a family. +2

5. Martha's future appears to be "brighter" without a child. +1

6. Martha, while somewhat unsure of her religious convictions, does not accept the nurse's reasoning about the position of the church. -2

The result of this counseling session is pros (+8) and cons (-2) or a total of (+6). Martha decides to have an abortion at the hospital's clinic.
Nurse B discusses the following facts and judgments with Martha:

<table>
<thead>
<tr>
<th>Nurse B discusses the following facts and judgments with Martha:</th>
<th>Martha's feelings and concerns: (Same as with Nurse A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abortion is the termination of life. Nurse B tells Martha to think about Martha's own feelings as to when human life begins.</td>
<td>1. To abort means to kill a baby. Martha's &quot;deep-down&quot; or &quot;gut&quot; feeling is not to have an abortion.</td>
</tr>
<tr>
<td>2. The abortion, if performed, will be done under a general anesthetic so Martha will not feel any pain. Nurse B points out though that there may be some emotions felt after the abortion—Martha may or may not experience guilt, shame, loss, and sadness.</td>
<td>2. Martha gives no thought to how abortion is done or to the possible consequences and side effects of this procedure.</td>
</tr>
<tr>
<td>3. It is true, according to law, that Martha's parents need not give consent for an abortion to be performed. Nurse B explores Martha's feelings toward her parents. She asks Martha to consider the matter from the parent's viewpoint: Do they love her? Would they want to help her during this difficult period? Is Martha afraid to tell them because she would lose face in their eyes? Should Martha give her parents an opportunity to express their feelings and views? Would her parents be totally negative and non-supportive?</td>
<td>3. Martha does not want her parents to know about her pregnancy. Yet she has ambivalent feelings.</td>
</tr>
<tr>
<td>4. If abortion is against Martha's religious convictions, Nurse B cautions her to consider very carefully this aspect of the problem.</td>
<td>4. While not overly religious, Martha feels that abortion is against her religion.</td>
</tr>
<tr>
<td>5. Should Martha decide to have the baby, Nurse B explores the economic resources available to Martha.</td>
<td>5. Martha cannot afford a baby nor can her parents.</td>
</tr>
</tbody>
</table>
6. The ramifications of the decision to abort or not to abort are explored with Martha. Her future plans, such as the completion of her education, the goals she has, the way she sees herself, are all analyzed.

7. Nurse B suggests an alternative: adoption. She informs Martha of some of the aspects to be considered—such as: her parents would have to be told; plans would have to be made for her prenatal care; emotions which may be encountered during pregnancy and after delivery.

The results of this counseling session between Nurse B and Martha are listed in the following pro and con statements with the numerical value (as perceived by Martha) attached.

**Statement:**

1. Abortion is not painful. There is some question about the psychological sequelae but is not of great concern. 

   **Numerical Value:** +1

2. Neither Martha nor her parents can afford to support a child.

   **Numerical Value:** +2

3. The future would be more difficult for Martha if she had the baby. She needs to complete her education and ultimately become self-supporting.

   **Numerical Value:** +2

4. If her parents found out, she would lose face.

   **Numerical Value:** +2

5. Abortion is the termination of life. Martha does not want "to kill the baby."

   **Numerical Value:** -2
6. Martha, while afraid to
tell her parents, has the
feeling that they would
want to know and would
offer her love and support.

7. Abortion is against
Martha's religious beliefs.

8. One alternative suggested
--adoption--is a possible
solution to the problem.

9. Economic arrangements can
be made for maternity care.

10. Martha can resume her edu­
cation after the birth of
the baby.

The results of this counseling session is pros (+7) and cons
(-11) or a total of (-4). Martha decides not to have an abortion.

The above two situations represent the difference the counselor
or teacher can make in a given situation. But if the circumstances
surrounding Martha's case were different, would the results have been
the same? Would the weight given each statement be different if
Martha's history was as follows?

Martha, age 15, is a sophomore at a private school. She lives
with her parents in an exclusive upper-income suburb. Martha, from
early childhood, was reared to think independently and act accordingly.
Her parents are ultra-liberal. The entire family, on occasion, attends
the Protestant church.

In the previous situation, Martha placed great weight on finan­
cial, religious and parental considerations. In this example Martha is
more sophisticated and independent and perhaps less likely to be in­
fluenced (at least to such a great extent) by others. Martha's in­
dependent nature may weight heavily for abortion and her right to
control what happens to her body, or if she believes that human life begins at conception and if she values life, she may weight heavily for an alternative to abortion.

It is evident that there are many factors which may influence a person involved in a critical life situation. The circumstances, the person, her family, the counselor, all have an effect on the situation. What weight is given to each of these factors determines the action which will result. The amount of "demonstrable" truth available and employed, the use of an open approach—freely, fairly, and usefully; the weighting of facts and opinions; and the use of the quantitative treatment of probabilities are all vital elements in the resolution of a critical life issue.

In the final analysis, though, the solution accepted by the party concerned, remains controversial. Nevertheless, the process used to get a solution must be kindly, informed, open, and as unbiased as possible.
CHAPTER VIII

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Adult men and women, freely entering the nursing profession, must acquire knowledge and skills in the humanistic as well as the technical sciences. Their goals are to preserve health, to prevent disease, and to care for the ill and dying. In these pursuits they are called upon to counsel, guide, and instruct their clients in situations involving life issues. A critical life issue is defined as a human problem with the following characteristics: it causes disequilibrium in the individual's internal or external environment; it requires a solution that is in conflict with the individual's own values and beliefs or is at odds with solutions acceptable by the majority of the population; and it may require a solution within a prescribed period of time. Two examples of critical life issues were analyzed: abortion and euthanasia. The focus of the paper is ethics in daily practice, ethics on a one-to-one relationship, and ethics in the here and now where issues need to be resolved.

Scientific and technological advances in the last few decades have presented ethical dilemmas to nurses. It is not that the nurse is faced with new problems (for abortion and euthanasia are age-old) but rather the choices for solution are new and often radical. Further the practice of nursing has changed. The environment of practice and scope of responsibility have changed. Nurses are called upon to counsel and instruct their patients (clients) in situations involving ordinary and
extraordinary (critical) life issues. Nursing must adapt to technological changes, and it must address itself to the medical-moral problems these technological changes engender.

The purpose of this study was to philosophically analyze the ethical considerations, the rights and obligations of instruction, involved in the teaching and counseling of critical life issues to nurses. In this limiting context, the purposes were to:

1. Study the relationship between the nurse and her patients (clients, consumers) and the rights and obligations which arise from this relationship.
2. Study the relationship between nurse-faculty and nursing students and the rights and obligations which arise from this relationship.
3. Study the rights and obligations of instruction of the nurse-teacher as a teacher and as a clinical teacher in a professional health setting.

Conclusions and Implications

1. General Nursing Conclusions and Implications

1.1 The ethical considerations of instruction on critical life issues have not been formally taught in the professional schools of nursing. The need for the development of guidelines and curricula in this area is evident and acute.

1.2 The implications--religious, legal, moral, sociological--of critical life issues are manifold and complex. The complexity of the issues make it difficult to teach health professionals and patients objectively and comprehensively.

1.3 Because the nurse (and other health professionals) is not academically and clinically prepared to teach and counsel
patients (clients, consumers) on critical life issues, there is an acute necessity to develop "competent amateurs" in the area of teaching bioethics.

1.4 The practice of nursing has changed. The breadth and depth of its body of knowledge have changed. The environment of practice and scope of responsibility have changed. Nursing must adapt to the technological changes, and it must address itself to the medical-moral problems these technological changes engender. Nurses therefore must be prepared to teach and counsel patients on critical life issues.

1.5 The nurse/patient relationship is the basic building block of the nursing profession.

1.6 The student nurse/nurse-teacher relationship is the basic building block of nursing education.

2. Rights and Responsibilities of the Nurse

2.1 Rights of the nurse include:

2.11 The right to a sound, comprehensive basic nursing education program, in both the art and science of nursing.

2.12 The right to act as teacher and counselor to the patient, his family, and the community.

2.13 The right to be a patient's advocate.

2.14 The right to be held accountable and responsible for her professional actions and judgments.

2.15 The right to continuing professional education.

2.2 The responsibilities of the nurse are closely aligned with her rights. The responsibilities of the nurse are outlined in the first code written for nurses, the Nightingale Pledge, and the
American Nurses' Association Code for Nurses. The legal responsibilities of the nurse are spelled out in the various Nurse Practice Acts of the individual states.

2.3 Nurse and patient rights and responsibilities are often so closely interwoven that it is difficult to separate them.

3. The Rights and Responsibilities of the Patient

3.1 The rights of the patient are outlined in the "Patient's Bill of Rights" as formulated by the American Hospital Association and the various codes of ethics of the nursing and medical professions.

3.2 The following rights of the patient are acknowledged by the major codes and statements of the nursing profession, the medical profession, and the hospital associations, and are generally accepted by the other health professionals and the public:

3.21 Right to be treated with dignity.
3.22 Right to confidentiality.
3.23 Right to privacy.
3.24 Right to competent care.
3.25 Right to informed consent.
3.26 Right to refuse treatment.
3.27 Right to complete current information concerning one's condition.
3.28 Right to know what hospital rules and regulations apply to his conduct as a patient.
3.3 Other rights of the patient acknowledged by the health professions, but which are not generally accepted by the public and some of the health profession members are:

3.31 Right to health service and treatment.

3.32 Right to an environment—physical, social, spiritual—conducive to health.

3.33 Right to health education and counseling.

3.34 Right to representation by a guardian or advocate (if necessary).

3.4 The rights of the patient which are not generally accepted by the health professionals and the public and which are emotionally charged and hotly disputed, are:

3.41 Right to control over one's body.

3.42 Right to life.

3.43 Right to die.

3.5 Historically, the patient has only been "responsible" for cooperating with the medical treatment he has agreed to with his doctor. The patient has no other responsibilities.

4. Rights and Responsibilities of the Nurse-Teacher

4.1 There is a need for the rights and responsibilities of the nurse-teacher, as such, to be developed. A "Nurse-Teacher Bill of Rights" and a "Code of Ethics for the Nurse-Teacher" was proposed.

4.11 The proposed "Nurse-Teacher Bill of Rights" listed the following rights:
4.111 The right to the opportunity to know herself, her capabilities, her assets, her liabilities, her values, her philosophy.

4.112 The right to an educational program designed to prepare her not only to be a specialist in her area of study, but also as a health teacher and counselor.

4.113 The right to an interdisciplinary approach in her academic preparation as a teacher of nurses.

4.114 The right to refuse to teach subjects which she is not qualified by academic preparation or experience to teach.

4.115 The right to programs designed to prepare her in the areas of teaching critical life issues.

4.12 The proposed "Code of Ethics for the Nurse-Teacher" emphasized the commitment of the nurse-teacher to the student, the patient, the family, the community, the physician and other health professionals.

4.2 The rights and responsibilities of the nurse-teacher resulted in the emergence of two needs: the need for prepared nurse-faculty in the area of bioethics and the need for financial support of the nursing program in ethics.

5. Preparation of the Nurse-Teacher

5.1 The preparation of the nurse-teacher (and the nurse) needs to be studied and revised. The curriculum content, design, and execution of professional nursing education programs must
likewise be studied, revised, and in some instances, initiated.

5.2 Recommendations for the graduate preparation of the nurse-teacher include:

5.21 The preparation of the nurse-educator be in an environment which is conducive to learning and which promotes dynamic solid thinking. Courses in the scientific method, the nursing process, and decision-making should be a vital, integral part of the student's program.

5.22 The preparation of the nurse-educator should include, as a vital integral part of the student's program, courses which help the student to become aware of and be able to analyze her own philosophy of life, her values and attitudes and their effect on the decisions and actions of others.

5.23 The preparation of the nurse-educator should include in the formal program courses in ethics. These courses should be mandatory and be designed primarily to meet the needs of the nurse-educator.

5.24 The preparation of the nurse-educator should include courses in the areas of counseling and guidance. This preparation consists of theory and practice in the clinical settings—hospital, home, clinic, work.

5.25 The position of "professor of ethics" or its counterpart should be established and provided for on all nursing school faculties of graduate education.
6. The Ethical Considerations of Teaching Critical Life Issues

6.1 The teaching of critical life issues was approached from three main areas of interest: the teacher; the program; and the process.

6.11 There is a need for qualified nurse-teachers in the area of bioethics. The ideal teacher would have professional competence in both ethics and nursing.

6.111 Two courses of action to temporarily solve the problem of qualified bioethics faculty are: the development of the "competent amateur" and the team approach to the teaching of bioethics in nursing.

6.12 The program structure for the teaching of bioethics endorsed in this paper is a combination of the isolated and integrated approaches to the teaching of bioethics. The program structure recommended is:

6.121 A basic core content of bioethics should be developed which is specific to and appropriate for medical schools, nursing schools, and other health professional schools.

6.122 Bioethics should be integrated throughout the educational programs of the health professional schools. Curriculum design should match the content of the bioethics program with other courses and clinical experiences.
6.123 In areas of mutual interest and concern, joint programming for physicians and nurses should be developed.

6.13 The process for teaching bioethics is a combination of methods proposed by Edward L. Thorndike: the use of demonstrable truth (hard-data) and an open approach (freely, fairly, usefully).

6.131 A teaching model for a life issue is offered as a sample teaching tool.

6.132 A hypothetical case of a patient with a problem involving abortion is offered as a sample of teaching techniques and philosophies and their effects on patients.

Recommendations for Further Study

1. A study of the kind and extent of teaching programs in bioethics for nurses currently available.

2. A study of the feasibility of establishing a post-graduate program for the nurse-educator seeking "competent amateur" and "professor of ethics" status.

3. A study of the educational resources, hard- and soft-ware, which are available and designed specifically for the nurse.

4. A study of the attitudes of the medical and nursing educators concerning the establishment of a core ethics program.

5. A study of the attitudes of the health professionals concerning the feasibility of the team approach to the teaching of bioethics to all health professionals.
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APPENDIX A
THE LIVING WILL

TO MY FAMILY, MY PHYSICIAN, MY LAWYER, MY CLERGYMAN
TO ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE
TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH, WELFARE OR AFFAIRS

Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I, ___________________________ can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures". I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed ____________________________________________

Date ____________________________

Witness ____________________________________________

Witness ____________________________________________

Copies of this request have been given to ____________________________________________
________________________________________________________
________________________________________________________

Formulated by the Euthanasia Educational Council, New York, New York.
APPENDIX B

COMPETENCIES DEEMED DESIRABLE IN A TEACHER OF NURSING

By Alice Ruby Major

1. She should maintain command of a considerable body of concrete information about her world, her culture and herself which she is able discriminately to apply to her work as a teacher and a faculty member.

2. She should be able to speak and write so that her thinking is communicated to her audience in a well organized, comprehensible, interesting way.

3. She should be a scholar of nursing who is able to delineate its structure, keep abreast of advances in its knowledge and techniques, and put what she knows into instructional form.

4. She should be acquainted with the skills of factual research and be able to engage in conceptual research.

5. She should be able democratically to guide individuals and groups to desirable, stable changes in behavior.

6. She should be able to infuse teaching with moral and spiritual values, a sense of the worthwhileness of nursing, and a general expectancy of individual and group excellence.

7. She should be able to create both clinical and academic learning situations that stimulate disciplined, critical, creative, individual intellectual effort; that favor the learning and application of principles and concepts; that provide opportunities to practice desired behavior; that examine and interpret experience and develop a desire to continue learning.

8. She should be familiar with a wide range of teaching methods and materials; be able to select those most efficient in accomplishing specific objectives and use them effectively for this purpose in those proportions necessary to develop the physical and intellectual skills of nursing.

9. She should understand the nature and purpose of contemporary professional undergraduate education, and in the light of this be able to define cooperatively essential, achievable, content and behavior objectives for the curriculum in nursing and for her area of teaching in relation to them; and identify the nature and organization of learning experiences needed for their accomplishment.
10. She should be able to make an accurate, critical assessment of academic and clinical resources in relation to their potential contribution to teaching and learning; of the accomplishments of students in relation to both objectives and processes and methods of instruction; and identify the learning, teaching and curricular implications of her findings.
APPENDIX C

NATIONAL EDUCATION ASSOCIATION OF THE UNITED STATES "CODE OF ETHICS"

"Code of Ethics"

Preamble

The educator believes in the worth and dignity of man. He recognizes the supreme importance of the pursuit of truth, devotion to excellence, and the nurture of democratic citizenship. He regards as essential to these goals the protection of freedom to learn and to teach and the guarantee of equal educational opportunity for all. The educator accepts his responsibility to practice his profession according to the highest ethical standards.

The educator recognizes the magnitude of the responsibility he has accepted in choosing a career in education, and engages himself, individually and collectively with other educators, to judge his colleagues, and to be judged by them, in accordance with the provisions of this code.

Principle I--Commitment to the Student

The educator measures his success by the progress of each student toward realization of his potential as a worthy and effective citizen. The educator therefore works to stimulate the spirit of inquiry, the acquisition of knowledge and understanding, and the thoughtful formulation of worthy goals.

In fulfilling his obligation to the student, the educator--
1. Shall not without just cause restrain the student from independent action in his pursuit of learning, and shall not without just cause deny the student access to varying points of view.
2. Shall not deliberately suppress or distort subject matter for which he bears responsibility.
3. Shall make reasonable effort to protect the student from conditions harmful to learning or to health and safety.
4. Shall conduct professional business in such a way that he does not expose the student to unnecessary embarrassment or dis­paragement.
5. Shall not on the ground of race, color, creed, or national origin exclude any student from participation in or deny him benefits under any program, nor grant any discriminatory consideration or advantage.
6. Shall not use professional relationships with students for private advantage.
7. Shall keep in confidence information that has been obtained in the course of professional service, unless disclosure serves professional purposes or is required by law.
8. Shall not tutor for remuneration students assigned to his classes, unless no other qualified teacher is reasonably available.

Principle II--Commitment to the Public

The educator believes that patriotism in its highest form requires dedication to the principles of our democratic heritage. He shares with all other citizens the responsibility for the development of sound public policy and assumes full political and citizenship responsibilities. The educator bears particular responsibility for the development of policy relating to the extension of educational opportunities for all and for interpreting educational programs and policies to the public.

In fulfilling his obligation to the public, the educator--
1. Shall not misrepresent an institution or organization with which he is affiliated, and shall take adequate precautions to dis­tinguish between his personal and institutional or organizational views.
2. Shall not knowingly distort or misrepresent the facts con­cerning educational matters in direct and indirect public expressions.
3. Shall not interfere with a colleague's exercise of political and citizenship rights and responsibilities.
4. Shall not use institutional privileges for private gain or to promote political candidates or partisan political activities.
5. Shall accept no gratuities, gifts, or favors that might impair or appear to impair professional judgment, nor offer any favor, service, or thing of value to obtain special advantage.
Principle III—Commitment to the Profession

The educator believes that the quality of the services of the education profession directly influences the nation and its citizens. He therefore exerts every effort to raise professional standards, to improve his service, to promote a climate in which the exercise of professional judgment is encouraged, and to achieve conditions which attract persons worthy of the trust to careers in education. Aware of the value of united effort, he contributes actively to the support, planning, and programs of professional organizations.

In fulfilling his obligation to the profession, the educator—

1. Shall not discriminate on the ground of race, color, creed, or national origin for membership in professional organizations, nor interfere with the free participation of colleagues in the affairs of their association.
2. Shall accord just and equitable treatment to all members of the profession in the exercise of their professional rights and responsibilities.
3. Shall not use coercive means or promise special treatment in order to influence professional decisions of colleagues.
4. Shall withhold and safeguard information acquired about colleagues in the course of employment, unless disclosure serves professional purposes.
5. Shall not refuse to participate in a professional inquiry when requested by an appropriate professional association.
6. Shall provide upon the request of the aggrieved party a written statement of specific reason for recommendations that lead to the denial of increments, significant changes in employment, or termination of employment.
7. Shall not misrepresent his professional qualifications.
8. Shall not knowingly distort evaluations of colleagues.

Principle IV—Commitment to Professional Employment Practices

The educator regards the employment agreement as a pledge to be executed both in spirit and in fact in a manner consistent with the highest ideals of professional service. He believes that sound professional personnel relationships with governing boards are built upon personal integrity, dignity, and mutual respect. The educator discourages the practice of his profession by unqualified persons.

In fulfilling his obligation to professional employment practices, the educator—

1. Shall apply for, accept, offer, or assign a position or responsibility on the basis of professional preparation and legal qualifications.
2. Shall apply for a specific position only when it is known to be vacant, and shall refrain from underbidding or commenting adversely about other candidates.
3. Shall not knowingly withhold information regarding a position from an applicant or misrepresent an assignment or conditions of employment.
4. Shall give prompt notice to the employing agency of any change in availability of service, and the employing agent shall give prompt notice of change in availability or nature of a position.
5. Shall adhere to the terms of a contract or appointment, unless these terms have been legally terminated, falsely represented, or substantially altered by unilateral action of the employing agency.
6. Shall conduct professional business through channels, when available, that have been jointly approved by the professional organization and the employing agency.
7. Shall not delegate assigned tasks to unqualified personnel.
8. Shall permit no commercial exploitation of his professional position.
9. Shall use time granted for the purpose for which it is intended.
APPENDIX D

THE NIGHTINGALE PLEDGE*

I solemnly pledge myself before God, and in the presence of this assembly.

To pass my life in purity and to practice my profession faithfully.

I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping of all family affairs coming to my knowledge in the practice of my profession.

With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

*This pledge was formulated in 1893 by a committee of which Mrs. Lystra E. Gretter, R.N., was the chairman. It was first administered to the 1893 graduating class of the Farrand Training School, now the Harper Hospital, Detroit, Michigan.
APPENDIX E

AMERICAN NURSES' ASSOCIATION CODE FOR NURSES

The Code for Nurses is based on belief about the nature of individuals, nursing, health, and society. Recipients and providers of nursing services are viewed as individuals and groups who possess basic rights and responsibilities, and whose values and circumstances command respect at all times. Nursing encompasses the promotion and restoration of health, the prevention of illness, and the alleviation of suffering. The statements of the Code and their interpretation provide guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and quality in nursing care.

CODE FOR NURSES

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.
The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7 The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8 The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9 The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10 The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient’s continuing health care requirements following discharge.

11 The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12 The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.
Nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery and stress the prevention of illness and promotion of health by teaching and example. They render health-service to the individual, the family and the community and co-ordinate their services with members of other health professions.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is based on human need and is therefore unrestricted by considerations of nationality, race, creed, colour, politics or social status.

Inherent in the code is the fundamental concept that the nurse believes in the essential freedoms of mankind and in the preservation of human life. It is important that all nurses be aware of the Red Cross Principles and of their rights and obligations under the terms of the Geneva Conventions of 1949.

The profession recognises that an international code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

1. The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health.
2. The nurse shall maintain at all times the highest standards of nursing care and of professional conduct.
3. The nurse must not only be well prepared to practise but shall maintain knowledge and skill at a consistently high level.
4. The religious beliefs of a patient shall be respected.
5. Nurses hold in confidence all personal information entrusted to them.
6. Nurses recognise not only the responsibilities but the limitations of their professional functions; do not recommend or give medical treatment without medical orders except in emergencies, and report such action to a physician as soon as possible.
7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.
8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.
9. The nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides.
10. Nurses do not permit their names to be used in connection with the advertisement of products or with any other forms of self advertisement.
11. The nurse co-operates with and maintains harmonious relationships with members of other professions and with nursing colleagues.
12. The nurse adheres to standards of personal ethics which reflect credit upon the profession.
13. In personal conduct nurses should not knowingly disregard the accepted pattern of behaviour of the community in which they live and work.
14. The nurse participates and shares responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public—local, state, national and international.

Adopted by the ICN in 1953 and revised by the Grand Council in Frankfurt, Germany, June, 1965.
APPENDIX H

AMERICAN MEDICAL ASSOCIATION - "PRINCIPLES OF MEDICAL ETHICS"

Preamble: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient’s ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.
I swear by Apollo, the Physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

To reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required: to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With Purity and with Holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.
APPENDIX J

HUMAN EXPERIMENTATION CODE OF ETHICS OF THE WORLD MEDICAL ASSOCIATION

Human Experimentation
Code of Ethics of the World Medical Association

A draft code of ethics on human experimentation drawn up by the World Medical Association was published in the British Medical Journal of 27 October, 1962. The original draft of this was in English. A revised version was accepted as the final draft at the meeting of the World Medical Association in Helsinki in June 1964. The original of this draft was in French, of which the W.M.A.'s English version is printed below. It is to be known as the Declaration of Helsinki.

DECLARATION OF HELSINKI

It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words, 'The health of my patient will be my first consideration'; and the International Code of Medical Ethics which declares that 'Any act of advice which could weaken physical or mental resistance of a human being may be used only in his interest.'

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil, and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognised between clinical research in which the aim is essentially therapeutic for a patient, and clinical research the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I Basic Principles

1. Clinical research must conform to the moral and scientific principles that justify medical research, and should be based on animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II Clinical Research Combined with Professional Care

1. In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgment it offers hope of saving life, re-establishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the
doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III Non-Therapeutic Clinical Research

1. In the purely scientific application of clinical research carried out on a human being it is the duty of the doctor to remain the protector of the life and health of that person on whom the clinical research is being carried out.

2. The nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent, after he has been fully informed; if he is legally incompetent the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject, even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued. The investigator or the investigating team should discontinue the research if in his or their judgment it may, if continued, be harmful to the individual.
APPENDIX K

THE NUREMBERG CODE.

United States Versus Karl Brandt, et al.*

Nuremberg Military Tribunal

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.
APPENDIX L

THE GENEVA CONVENTION CODE OF MEDICAL ETHICS

The Geneva Convention Code of Medical Ethics
Adopted by the World Medical Association in 1949.

I solemnly pledge myself to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude which is their due;
I will practice my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets which are confided in me;
I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
My colleagues will be my brothers;
I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
I will maintain the utmost respect for human life from the time of conception; even under threat. I will not use my medical knowledge contrary to the laws of humanity.
I make these promises solemnly, freely and upon my honour.
APPENDIX M

NAACOG STATEMENT ON ABORTIONS AND STERILIZATIONS (1972)

The Nurses Association of The American College of Obstetricians and Gynecologists recognizes that current knowledge of human behavior, population pressure and changes in medical technology challenge the position traditionally held regarding interruption of pregnancy.

We are aware of our nursing role in relation to cooperating with team members in meeting the health care needs of the woman seeking an abortion or sterilization. Genuine concern and compassion for this woman is strongly urged. However, there may be concern regarding nursing practice and participation in this particular area of health care. It is therefore our aim to recommend that an individual's rights must be maintained and safeguarded by written policies.

The Association recommends the following principles and guidelines:

1. Nurses have the responsibility to provide nursing care.

2. Nurses have the right to refuse to assist in the performance of abortions and/or sterilization procedures in keeping with their moral, ethical and/or religious beliefs, except in an emergency when a patient's life is clearly endangered, in which case the questioned moral issue should be disregarded. This refusal should not jeopardize the nurses' employment nor should they be subjected to harassment or embarrassment because of their refusal.

3. Nurses, in dealing with such patients, should not impose their views on the patients or personnel.

4. Nurses have the right to expect their employers to describe to them the hospital's policies and practices regarding abortions and sterilizations.

5. Nurses have the obligation to inform their employers of their attitudes and beliefs regarding abortions and sterilizations.
Research on the fetus and newborn is of the greatest importance in contributing to the health and welfare of the entire population. Such research, motivated by humane concern, should be continued and fostered, subject to adequate and clearly defined safeguards.

The American Academy of Pediatrics recognizes that through research involving preivable fetuses, new knowledge may be gained which would ultimately benefit viable infants. The American Academy of Pediatrics also recognizes that some of these areas of research, while not jeopardizing the health and welfare of the fetus, are not of direct benefit to that particular fetus. In such cases express consent should be obtained from the parent. "The whole preivable fetus has offered an important opportunity that cannot be obtained in any other way for making observations of great value on the transfer of substances across the human placenta, the reaction of the immature fetus to drugs, and on the endocrinological development of the fetus and the development of the placenta."1

Research activities involving the fetus in utero or pregnant women may be undertaken for the purpose of benefiting that particular fetus or to respond to the health needs of the mother, as part of the procedure to terminate the pregnancy, and for the purpose of evaluating or improving methods of prenatal diagnosis, methods of prevention of premature birth, or methods of intervention to offset the effects of genetic abnormality or congenital injury or to ascertain the safety and efficacy to the fetus of drugs which might be needed by pregnant women.2

For the purposes of this code of recommendations, the following definitions have been accepted:

Viability of the fetus means the ability of the fetus, after either spontaneous or induced delivery, to survive (given the benefit of medical therapy) to the point of independently maintaining heart beat and respiration. If the fetus has this ability, it is viable and therefore a premature infant.

Abortus means a fetus when it is expelled whole, prior to viability, whether spontaneously or as a result of medical or surgical intervention. The term does not apply to the placental fetal material which is macerated at the time of expulsion; or cells, tissue, or organs excised from a dead fetus.3

Because of the rapid changes taking place in medical knowledge, the definition of viability should be reviewed regularly in order that it be consistent with these rapid changes.

Determination of viability entails a subjective and objective judgment by the physician attending labor or examining the product of conception, and must be made by a physician other than the investigator wishing to use fetal tissue in research. In general, and all other circumstances notwithstanding, a beating heart alone is not sufficient evidence of viability. At least one additional necessary condition is the possibility that the lungs can be inflated. Without this precondition, no currently available mechanisms to initiate or
maintain respiration can sustain life; and in this
case, though the heart is beating, the fetus or
abortus is in fact nonviable.\

CODE

(1) Research on the fetus in utero (where
delivery of a previable fetus is not contemplated):
Investigations and tests may be carried out with
the intention of benefiting the mother, her
expected child, or both. For these investigations
and tests, informed consent should be obtained.

(2) Research on the viable fetus: When the
fetus is viable after delivery, the ethical obligation
is to sustain its life so far as possible. It is both
unethical and illegal to carry out any experiments
which are inconsistent with treatment necessary
to promote the life of the fetus. It is recognized
that in many instances the techniques used to aid
a distressed fetus may be so new that in some
degree they may be considered experimental.

(3) Research on the previable fetus in utero
(where abortion is planned) or abortus: This
research is permissible providing: (a) animal stud-
ies, if appropriate, have been completed; (b) the
mother and father are legally competent and have
given their consent, except that the father’s
consent need not be secured if his identity or
whereabouts cannot reasonably be ascertained;
(c) individuals engaged in the research will have
no part in: (1) any decisions as to the timing,
method, or procedures used to terminate the
pregnancy, and (2) evaluating the viability of the
fetus at the termination of the pregnancy; (d) such
research is only carried out in departments
directly related to a medical institution and with
the express sanction of its committee on human
experimentation; (e) before permitting such
research the committee on human experimenta-
tion satisfy itself: (1) on the validity of the
research; (2) that the required information cannot
be obtained in any other way, and (3) that the
investigators have the necessary facilities, skill,
and integrity; (f) dissection of the dead fetus or
experiments on the fetus or fetal material do not
occur in the operating theatre or place of deliv-
ery; (g) there is no monetary exchange for fetuses
or fetal material; (h) full records are kept by the
relevant institution.

(4) Research on the dead fetus or abortus: This
research is permissible provided the conditions in
paragraph 3 (b to h) above are observed and the
research conducted in accordance with any appli-
cable state or local laws governing autopsy.

If the abortus is an organ or tissue donor, the
research shall be conducted in accordance with
any applicable state or local laws governing
transplantation or anatomical gifts.

TASK FORCE ON PEDIATRIC RESEARCH,
INFORMED CONSENT AND MEDICAL ETHICS

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Subjects, November 16, 1973, p. 31740, G.
Research is an essential means for developing the scientific foundations of nursing practice. The ethical premises which apply to research activities must be an integral component of the research process. Recognizing a major responsibility for formulating definitive statements regarding those ethical values which pertain to all aspects of nursing, including research, the American Nurses' Association, the professional association of registered nurses, through the Standing Committee on Research and Studies, has developed ethical guidelines for nurses in research. These guidelines are an extension of the principles enunciated in the ANA Code for Professional Nurses.

The statement, The Nurse in Research: ANA Guidelines on Ethical Values, was approved by the ANA Board of Directors in January, 1968. It represents a point of view consonant with the current status of research in this country. These guidelines, in delineating the rights and responsibilities of the nurse in research, will not only serve as a guide for nurses engaged in research, but will also identify for members of the health care professions and of society the expectations concerning the nurse researcher which can legitimately be held. Knowledgeable application of these guidelines by nurses in research will provide the ethical dimension of the search for new knowledge through which the nursing care needs of society can be met.

Jo Eleanor Elliott
President (1964-1968)
American Nurses' Association

Nursing has a long history of service to mankind. The American Nurses' Association, the professional association of nurses, has exemplified this dedication to quality nursing care in the United States since the association's founding in 1897. The American Nurses' Association has provided the stability and vision needed to guide nurse practitioners in rendering nursing care which embodies today's scientific, technological, sociological, and economic changes.

Nursing is committed to the identification and elaboration of a body of scientific knowledge specific to nursing. This knowledge represents the descriptive, explanatory, and predictive principles that guide nursing practice for the provision of optimal nursing services to society. Such knowledge is the consequence of the great freedom of inquiry employed in science's quest to achieve mastery of all that is knowable in the universe.

Research is the chief means of expanding the scientific parameters of a discipline. Each profession has the responsibility to carry forward research activities which will provide the scientific bases for the professional practice of its members. Each profession, through its community of practitioners, educators and researchers, must determine its own goals and the most appropriate means of achieving these goals for the greatest good to society.

The American Nurses' Association reaffirms its belief in the rights and the responsibilities of the members of the profession of nursing to conduct research which will advance knowledge and improve the practice of nursing. In its commitment to the advancement of nursing knowledge, the association supports and encourages research policies and practices which are essential to the conduct of sound scientific inquiry and adhere to the ethical premises established by the ANA Code for Professional Nurses.

The American Nurses' Association, in meeting its obligations to the profession of nursing and to society further believes that guidelines on ethical values for nurses in research are needed. These guides are designed to establish a broad context within which nurses can fulfill their research roles and to provide members of other disciplines and the public premises upon which to base their expectations of the nurse investigator.

The Nurse in the Research Setting

Nurses in the research setting generally assume one of two roles: The investigator role, including membership on a research team; or the nurse practitioner giving patient care in the setting where research is being conducted. Many research designs require that the investigator be an objective observer of behavior or nursing intervention rather than a participant in the interaction. Also, the simultaneous maintenance of dual roles, researcher and nurse practitioner, may not always obtain in the research setting, thus consequent neglect of one or
the other function might occur. Therefore, in these instances it is important that the two roles, investigator and practitioner, be considered mutually exclusive in order that the quality of the research or of patient care not suffer.

Investigator
The investigator is a registered nurse who has achieved the educational and technical competence to perform the conceptualizing, supervisory, collaborative, and evaluative functions inherent in the investigative role. The nurse researcher has freedom of inquiry—the right to conduct research which he believes will contribute to scientific knowledge or the advancement of nursing practice. Further, research in nursing practice should be under the direction of a qualified nurse researcher. Ultimate responsibility for adherence to scientifically sound and ethically valid methods and procedures in a study rest with the investigator. The researcher is also obligated to maintain objectivity and fidelity to these scientific and ethical premises in reporting findings. The investigator is accountable to his peer group, both within and without the profession of nursing, and to society for the performance of his chosen work.

Nurse Practitioner
The nurse practitioner is responsible for rendering quality nursing care to patients in the research setting.

Nursing practice in the research setting adheres to the principles enunciated in the ANA Code for Professional Nurses. The nurse practitioner does not carry a decision-making function in the planning, conduct, and evaluation of research, but must be informed sufficiently about the research design to enable him to participate in the required procedures in an ethical fashion.

Peer Group Roles
In addition to the close collaborative relationships which must exist in a research team, the discussion and consultation among colleagues and senior associates in the nursing profession, enjoyed by the nurse investigator, enrich the quality of the research product.

While the responsibility for the preservation of patient rights, for the maintenance of the integrity of the research design, and for a full reporting of the research findings, ultimately rests with the principal investigator, a review committee of peers, not a part of the investigational team, is a marked asset in any investigation. It provides an additional element of ethical protection to all participants in an investigation—subjects, the investigator(s), the persons responsible for maintaining subject well-being, and the sponsoring institution or agency.

The latter is chiefly responsible for ensuring that the investigator and the employing institution are aware of the ethical implications of the research and have taken the necessary steps to discharge their responsibilities to the subjects involved.

Institutions differ widely in their structure and operational procedures. The working arrangements between and among agencies also vary. Therefore, the methods which might be used in establishing a review committee and in making it an effective body in the research process must be left to the institutions involved. In situations where review committees are operant, the nurse investigator should seek the committee’s advice and comments. If no review committee is in existence, nurse researchers should take an active role in initiating the formation of such a group so essential to quality research.

Protection of Human Rights

Society places certain areas of individual rights in eminent position—privacy; self-determination; conservation of personal resources such as time, dignity, and energy; freedom from arbitrary physical or mental hurt by others; and freedom from intrinsic risk of emotional or physical injury. Nursing stresses these values. The preservation of these rights must be an integral part of nursing research. The participation of human beings as research subjects is based upon trust that these rights will be respected in the development and implementation of the research design.

The relationship of trust between subject and investigator requires that the subject be assured that he will be treated fairly; and that no discomfort, risk, or inconvenience, beyond that initially stated in discussing the subject’s role in the study, will be imposed without further permission being obtained from the subject.

In those studies where the individuals are mentally competent and of sufficient age to make an informed choice, based on recognition and reasonable understanding of what is to occur, the investigator must also disclose to prospective subjects certain information about the research design. This includes information about the purposes of the inquiry and the procedures to be used, particularly those which directly involve the subject. The individual must be advised of the real or potential consequences of these procedures—nature, extent, and duration of discomfort or loss of dignity or autonomy, and the degree of risk involved. The subject should also have some assurance that his investment of personal resources is worthwhile and of potential use to society if not of direct benefit to him. When the complexity of the project is beyond the comprehension of a subject or the nature of the project precludes revealing its purpose, the investigator must be guided by professional judgment and the advice and direction of the review committee of peers, established in the particular research
setting, as to the level of disclosure which is required to protect the rights of the individual and those of society. Ethical concerns about the potential violation of these human rights become crucial when new and untried techniques and procedures are to be used, when the degree of intrinsic risk is either unknown or is presumed to be notably greater than that encountered in everyday life, or when the probable outcomes are either unknown or quite doubtful. The development and refinement of the scientific premises of nursing may involve the investigator in ethical considerations which pertain to one or more of these areas. The investigator must seek, by every means at his disposal, to ensure that the rights of subjects are rigorously protected throughout all phases of the investigation.

Right of Privacy
The right of an individual to privacy—his freedom to determine how much of his thoughts, feelings, attitudes, values, and personal information shall be divulged in a given context—is protected during the course of a scientific investigation through the requirement that subjects give their free and informed consent to participate in the study. The subject agrees to share with the investigator certain specific personal information about himself which he may or may not choose to divulge to others in a different context. In return, the investigator provides assurances to the subject that his anonymity will be protected both during the study and in the reporting of the research findings, and that the information which the researcher obtains about the subject will be held in confidence. A plan of study or reporting which sacrifices subject anonymity or confidentiality must be made known to the subject prior to his giving consent. When such an agreement obtains and is adhered to by the persons concerned, no invasion of privacy occurs, regardless of the nature of the information revealed.

Right of Self-Determination
Self-determination or autonomy is another valued area of human rights. One protection of this right is the requirement that the investigator obtain the free and informed consent of each subject before the study is begun. The subject's consent must be voluntarily given, without overt or covert coercion, and without deception being practiced upon the subject. Should the research design require some degree of concealment of the true purpose or methodology of the study, the design should also provide for subsequent disclosure of the nature of the concealment and the rationale for it having been a part of the procedure.

The right of self-determination also implies that the subject is free to withdraw his consent to participate in the investigation at any point in the study continuum, and he must be so advised of this prerogative.

On occasion, a research design will involve procedures or possible outcomes which may impinge upon the rights of a third party such as a spouse. If it is established that valid third party interest in the research procedures may exist, the informed consent of the third party to utilize the proposed subject in the study should also be obtained.

Right of Conservation of Personal Resources
Individuals vary widely as to the value they place on each of their personal resources such as time, freedom from constraint, or energy expenditure. In making the request of a subject for the use of specified personal resources in a study or experiment, the investigator should provide the subject with information about the nature, extent, and possible consequences to the subject that the giving of personal resources might entail.

Right to Freedom from Arbitrary Hurt
Practitioners in the health professions, by virtue of their calling, seek to protect individuals under their care from arbitrary physical or mental suffering or hurt. However, it might be pointed out that the less able the individual is in protecting himself from externally imposed threat or injury the greater the vigilance of the nurse researcher must be that such injury does not occur.

Right to Freedom from Intrinsic Risk of Injury
In studies where the nature of the research design subjects the individual to risk of emotional or physical injury, the degree of risk must be measured against the amount of direct benefit the subject can expect from the procedures. Not only must the investigator afford the prospective subject full information about the proposed investigation, but he must also utilize the professional judgment of his peer group, such as members of the review committee, as well as his own in deciding whether or not to implement the research design.

Rights of Minors and Incompetent Persons
The design of investigations using minors or persons judged incompetent to handle their own affairs as subjects requires that the investigator give particular attention to safeguarding the rights of these individuals. The ready availability of children or incompetent persons as potential subjects does not make valid their choice as subjects. The choice of children or incompetent persons as research subjects can be justified only if there are benefits which will accrue to them or to others of the same class in the future.

The informed consent of parents or parent surrogates is obtained for investigations which use children as subjects. In the case of persons adjudged incompetent to handle their own affairs, the legal guardian is asked to
give consent. Minors who have the capacity to comprehend the implications of the proposed study should also be asked to give their consent, particularly if an element of risk to the subject is present. This consent supplements rather than supplants that of the parent or other legal agent.

The physical and emotional discomforts to be experienced by legally incompetent persons should be reduced to a minimum. Where intrinsic risk to the subject is involved, parental or surrogate consent may be inadequate. Thorough evaluation of the risk implications should be made by the review committee in these instances.

Information which is derived from individuals classed as legally incompetent must be handled in such a fashion that no disadvantage accrues to them, either during the study or as a result of dissemination of the findings.

**Manner of Consent**

There are investigational areas where, by the nature of the data used and the manipulations applied to it, consent by subjects is rarely required. This would apply largely to studies in which group characteristics are sought, using data from records or clinic observations.

In these studies, the information to be used and the techniques to be applied are accepted by a peer group as conventional, the identity of each individual is lost in the analysis and interpretation of the grouped data, and no potential harm will accrue to subjects as a consequence of the data collection or findings.

Studies which must be done without the consent of the subjects, i.e., behavioral responses of ethnic groups to a selected event in the everyday world, require the considered judgment of a peer group or of a public body as to the social need of the study and the necessity for a study of nonconsenting subjects.

In studies which ask that subjects surrender one or more of their rights, it is advisable that the investigator obtain written consent from the subject or his agent. Since content of the written consent may be subject to law which varies from state to state, only broad generalities can be discussed here.

Written consent by a subject should include a statement that the subject will voluntarily participate in the study. The statement should include information about the benefits expected from the research, either to the subject, to others of his same group in the future, or to the whole of society through the expansion of knowledge. The written consent must also contain stipulations about the nature and extent of the rights to be surrendered by the subject during the course of the study and of the real or potential risks to the subject as a consequence of his participation.

Since the investigator carries the major responsibility for ensuring that the rights of the subject are not violated, he must, throughout the course of the investigation and thereafter, scrupulously adhere to the mutual agreement, oral or written, entered into with each subject.

**Drugs Used in Research**

The administration or withholding of drugs as part of the research design requires that the nurse investigator fulfill two requirements. Inasmuch as the prescribing of drugs constitutes the practice of medicine, written authorization by a physician, licensed to practice medicine in the state where the study is to be conducted, is required in order to administer or to withhold drugs as part of the research design. The investigator must also obtain the consent of the individuals to whom the drugs are to be administered or of their representatives, following disclosure of the risks of discomfort or harm which may accrue to the subjects. Where full disclosure is not possible within the context of the research design, the approval of the reviewing body, however constituted in the research setting, must be obtained prior to beginning the investigation.

Investigations which involve the administration of experimental drugs to subjects may carry a high degree of risk to the latter. The use of these drugs is often under state or federal law, and such points as who may administer the drugs, the manner of record maintenance, and security measures may be stipulated in the documents permitting use of the drugs. The nurse investigator or the nurse providing patient care to the subjects must be sure that he is fully informed of the legal and pharmacological factors pertaining to the drug's use, and that he abides by the ANA Code for Professional Nurses.

**Animals in Research**

The complexity of scientific research designed to advance knowledge and understanding of the life process frequently requires that preliminary studies be done on living animals. The investigator must be competent in using animal research techniques. He must also avoid inflicting unjustifiable pain, suffering, or death on his animal subjects.

The researcher should procure research animals from reputable dealers who will ensure safe and humane transport of the animals they provide. The animals must also be humanely treated while they are in the laboratory setting, with careful attention given to the maintenance of animal health.
APPENDIX P

APA POSITION STATEMENT ON FAMILY PLANNING

This statement was approved by the Board of Trustees of the American Psychiatric Association at its December 14-15, 1973 meeting. It was prepared by the Task Force on Family Planning and Population.* The Assembly of District Branches endorsed the statement at its meeting on November 2-4, 1973.

INDIVIDUAL CHOICE as to whether and when to become a parent and the prevention of unwanted pregnancy or birth is an important way to promote and safeguard the health and welfare of individuals, families, and communities. Birth control, including contraception, medically safe abortion, and voluntary sterilization should therefore be available universally to every individual on request to prevent unwanted pregnancy or parenthood as a part of standard health care and medical services.

*The task force included: Eugene B. Brody, M.D., chairman; Robert Canero, M.D.; Stephen Fleck, M.D.; and E. James Lieberman, M.D.; Henry F. David, Ph.D.; Cornelia Friedman, M.D.; Zigmund M. Lebensohn, M.D.; Warren Miller, M.D.; Lucile Newman, Ph.D. and M.D.; Shelesnyak, Ph.D., consultants; Richard Barthel, M.D., Falk Fellow; John Cawte, M.D.; and James Fawcett, Ph.D., corresponding consultants; and Lane Ameen, M.D., liaison with the Council on Emerging Issues.
<table>
<thead>
<tr>
<th>The Dying Person's Bill of Rights</th>
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<tr>
<td>I have the right to be treated as a living human being until I die.</td>
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<tr>
<td>I have the right to maintain a sense of hopefulness however changing its focus may be.</td>
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<tr>
<td>I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.</td>
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<tr>
<td>I have the right to express my feelings and emotions about my approaching death in my own way.</td>
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<td>I have the right to participate in decisions concerning my care.</td>
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<td>I have the right to expect continuing medical and nursing attention even though “cure” goals must be changed to “comfort” goals.</td>
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<tr>
<td>I have the right not to die alone.</td>
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<td>I have the right to be free from pain.</td>
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<td>I have the right to have my questions answered honestly.</td>
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<td>I have the right not to be deceived.</td>
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<tr>
<td>I have the right to have help from and for my family in accepting my death.</td>
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<td>I have the right to die in peace and dignity.</td>
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<td>I have the right to retain my individuality and not be judged for my decisions which may be contrary to beliefs of others.</td>
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<tr>
<td>I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.</td>
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<tr>
<td>I have the right to expect that the sanctity of the human body will be respected after death.</td>
</tr>
<tr>
<td>I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.</td>
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This Bill of Rights was created at a workshop on "The Terminally Ill Patient and the Helping Person," in Lansing, Mich., sponsored by the Southwestern Michigan Inservice Education Council and conducted by Amelia J. Barbus, associate professor of nursing, Wayne State University, Detroit.
It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfillment of this mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words: "The health of my patient will be my first consideration" and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity. The World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and the clinical research, the essential object of which is purely scientific and without state of medicine nor can any one technological procedure be substituted for the overall judgment of the physician. If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with the performance of the transplantation.

Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation and in countries where the law permits, to remove organs from the cadaver provided that prevailing legal requirements of consent have been fulfilled.
APPENDIX S

DECLARATION OF SYDNEY

The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually he will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.

Two modern practices in medicine, however, have made it necessary to study the question of the time of death further: (1) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (2) the use of cadaver organs such as heart or kidneys for transplantation.

A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death of the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgment supplemented if necessary by a number of diagnostic aids of which the electroencephalograph is currently the most helpful. However, no single technological criterion is entirely satisfactory in the present therapeutic value to the person subjected to the research.

I. Basic Principles.

1. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.
II. Clinical Research Combined with Professional Care.

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope of saving life, reestablishing health, or alleviating suffering. If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. Non-Therapeutic Clinical Research.

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgment, it may, if continued, be harmful to the individual.
APPENDIX T

DECLARATION OF OSLO

1. The first moral principle imposed upon the doctor is respect for human life as expressed in a clause of the Declaration of Geneva: "I will maintain the utmost respect for human life from the time of conception."

2. Circumstances which bring the vital interests of a mother into conflict with the vital interests of her unborn child create a dilemma and raise the question whether or not the pregnancy should be deliberately terminated.

3. Diversity of response to this situation results from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected.

4. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the doctor within society.

5. Therefore, where the law allows therapeutic abortion to be performed, or legislation to that effect is contemplated, and this is not against the policy of the national medical association, and where the legislature desires or will accept the guidance of the medical profession, the following principles are approved:
   (a) Abortion should be performed only as a therapeutic measure.
   (b) A decision to terminate pregnancy should normally be approved in writing by at least two doctors chosen for their professional competence.
   (c) The procedure should be performed by a doctor competent to do so in premises approved by the appropriate authority.

6. If the doctor considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague.

7. This statement, while it is endorsed by the General Assembly of the World Medical Association, is not to be regarded as binding on any individual member association unless it is adopted by that member association.

Also called "Statement on Therapeutic Abortion" formulated by the World Medical Association, 1970.
DUTIES OF DOCTORS IN GENERAL

A doctor must always maintain the highest standards of professional conduct.
A doctor must practice his profession uninfluenced by motives of profit.
The following practices are deemed unethical:
   a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.
   b) Collaborate in any form of medical service in which the doctor does not have professional independence.
   c) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any act, or advice which could weaken physical or mental resistance of a human being may be used only in his interest.
A doctor is advised to use great caution in divulging discoveries or new techniques of treatment.
A doctor should certify or testify only to that which he has personally verified.

DUTIES OF DOCTORS TO THE SICK

A doctor must always bear in mind the obligation of preserving human life.
A doctor owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.
A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.
A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

DUTIES OF DOCTORS TO EACH OTHER

A doctor ought to behave to his colleagues as he would have them behave to him.
A doctor must not entice patients from his colleagues.
A doctor must observe the principles of "The Declaration of Geneva" approved by The World Medical Association.
APPENDIX V

THE CHRISTIAN AFFIRMATION OF LIFE

To my family, friends, physician, lawyer, and clergyman:

I believe that each individual person is created by God our Father in love and that God retains a loving relationship to each person throughout human life and eternity.

I believe that Jesus Christ lived, suffered, and died for me and that his suffering, death, and resurrection prefigure and make possible the death-resurrection process which I now anticipate.

I believe that each person's worth and dignity derives from the relationship of love in Christ that God has for each individual person and not from one's usefulness or effectiveness in society.

I believe that God our Father has entrusted to me a shared dominion with him over my earthly existence so that I am bound to use ordinary means to preserve my life but I am free to refuse extraordinary means to prolong my life.

I believe that through death life is not taken away but merely changed, and though I may experience fear, suffering, and sorrow, by the grace of the Holy Spirit, I hope to accept death as a free human act which enables me to surrender this life and to be united with God for eternity.

Because of my belief:

I request that I be informed as death approaches. If I can no longer take part in decisions concerning my own future and if there is no reasonable expectation of my recovery from physical and mental disability, I request that no extraordinary means be used to prolong my life.

I request, though I wish to join my suffering to the suffering of Jesus so I may be united fully with Him in the act of death-resurrection, that my pain, if unbearable, be alleviated. However, no means should be used with the intention of shortening my life.

I request, because I am a sinner and in need of reconciliation and because my faith, hope, and love may not overcome all fear and doubt, that my family, friends, and the whole Christian community join me in prayer and mortification as I prepare for the great personal act of dying.

Finally, I request that after my death, my family, my friends, and the whole Christian community pray for me, and rejoice with me because of the mercy and love of the Trinity, with whom I hope to be united for all eternity.

Signed ____________________________ Date ___________
APPENDIX W

A EUTHANASIA POSITION STATEMENT FORMULATED BY
ST. VINCENT HOSPITAL AND MEDICAL CENTER, TOLEDO, OHIO

It is one of the ethical principles of St. Vincent Hospital and Medical Center to uphold the sacredness of human life at all points and stages of its continuum. Consequently Euthanasia (positive) otherwise stated as "Mercy Killing" or euphemistically phrased as "Death with Dignity" is directly opposed to the preeminent value of human life.

While this institution recognizes and is dedicated to the betterment of every patient's "quality of life," nevertheless the "act of human life is recognized and held as a prior value to be respected, protected, and enhanced.

St. Vincent Hospital and Medical Center is unequivocally opposed to the legalization of Euthanasia and recognizes that the request for the legalization of "negative Euthanasia" is an ethical, political, and legal misnomer and subterfuge. Its purpose is to mislead as well as to condition the public to accept Euthanasia (positive) which is in fact and in effect legalized murder.

Furthermore, it is in the best interest of the mutual trust covenant between the physician and patient that the physician in consultation with the patient and/or relatives determines when it is no longer of medical benefit to prolong the dying process/event of the patient.

At present this mutual trust covenant is the accepted ethical practice and should not be legislated. In the opinion of the Ethical Review Committee of St. Vincent Hospital and Medical Center such legislation is considered to be ethically, politically, and legally counterproductive for all concerned.
The dissertation submitted by Evelyn G. Hartigan has been read and approved by the following committee:

Walter S. Krolakowski, S.J., Ph.D., Chairman
Professor of Educational Foundations

Rosemary V. Donatelli, Ph.D.
Associate Professor, Educational Foundations

John Wozniak, Ph.D.
Professor of Educational Foundations;
Dean, School of Education

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Education.

May 3, 1977

Date

W.P. [Signature]

Director's Signature