Healthcare and Clinical Ethics Annotated Bibliography


This revised/reorganized fifth edition of a classic exposition of a secular "principlist" approach to bioethics makes the text more accessible to readers who are not well versed in moral theory. The book addresses critiques of the approach as presented in earlier additions; new developments in theory; and new issues in research, medicine, and health care. The original framework containing four clusters of secular principles?*respect for autonomy, nonmaleficence, beneficence, and justice*?is upheld as "the common morality" accepted by "all morally serious persons." Often referred to as "the Georgetown mantra" (after Georgetown's Kennedy Institute of Ethics, where they were first drafted before publication in 1979), these principles have been widely accepted and have also been adapted in combination with other principles and concepts (see, for example, #9 in this bibliography). However, the framework has also provoked controversy and questions about its adequacy to resolve critical issues in bioethics and in clinical practice. In response, Beauchamp and Childress here offer an extended defense of their theory and critical examination of points of debate.

This edition consists of nine chapters divided into three parts, as well as an appendix of ten biomedical ethics cases. In Part I, chapter 1, entitled "Moral Norms," introduces the decision-making framework with attention to specifying and balancing principles and rules for moral deliberation and decision-making. Chapter 2, entitled "Moral Character," elaborates on moral
virtues and ideals as an often-neglected area in biomedical ethics. In Part II, chapters 3 through 6 present the four basic groups of principles, and chapter 7, "Professional-Patient Relationships," examines the moral rules of veracity, privacy, confidentiality, and fidelity in the context of relationships between researchers and research participants, as well as between health care professionals and patients. Part III consists of two chapters containing a detailed analysis of theories and methods in biomedical ethics. Chapter 8, "Moral Theories," reviews criteria for theory construction, as well as five types of moral theory: utilitarianism (consequence based), Kantianism (obligation based), liberal individualism (rights based), communitarianism (community based), and the ethics of care (relationship based). Chapter 9, "Method and Moral Justification," critically compares top-down and bottom-up models of justification and elaborates the preferred third model of "common morality" theory, illustrating its advantages with two other theories of common morality (those of William Frankena and W.D. Ross). The authors suggest that readers interested in moral theory consult these two concluding chapters immediately after reading the first two. According to Beauchamp and Childress, moral justification proceeds from "an expansive coherentist framework of norms that originate at all 'levels.'" They conclude that these norms can emerge from institutions, individuals, and cultures, and that "no norm is immune to revision."

No religious framework is considered broadly, and religious positions in bioethics are rarely, if ever, indexed. However, specific religiously grounded concepts can be tracked through names of theorists and occasionally through the concept itself via the extensive 22-page index. For instance, critical attention is given to the justification criteria behind distinctions made in certain end-of-life situations originating in Roman Catholic doctrine (such as the "ordinary versus extraordinary care" distinction and the rule of "double effect"). Beauchamp and Childress take into consideration the possible negative impact of certain lines of reasoning on deeply held societal beliefs and values (such as "respect for life"), but in the end they do not allow an "absolutist" prohibition of any decision, including, for example, physician-assisted suicide upon the request of a fully "autonomous" patient.


Benner, Tanner, and Chesla extend Benner's nursing classic From Novice to Expert: Excellence and Power in Clinical Nursing Practice (Addison-Wesley, 1984) with research from a six-year study (1988-1994) of 130 hospital nurses in 8 hospitals. Real-life nursing examples illustrate the progression from principle-based practice (guided by science, technology, and ethics) to response-based practice (guided by practical knowledge accumulated through engaged reasoning). Thirteen chapters are supported by a foreword from a practicing nurse, an introduction, references and bibliography, and an index, with three appendices on research methods and the nurse informants. Application to other disciplines (such as medicine, social work, teaching, occupational therapy, and physical therapy) is welcomed.

Key to the analysis is clearer recognition of the "existential skills of involvement" with patients and families, which the authors describe as "knowing how close or distant to be with patients and families in critical times of threat and recovery" and as "learned over time experientially." An "interpretive phenomenology" methodology, combining nurses' narratives and interview
responses, helped researchers access the nurses' everyday experience and skill in caring. The results challenge the technical-rationality model of professional practice that underlies most studies of both medical and nursing clinical judgment and demonstrate that abstract reasoning based on criteria alone fails to consider changes in patients' conditions and in the clinician's understanding of the unfolding clinical situation. "Disposition toward what is good and right is not a matter of individual ethics," explain the authors, "but is rather socially constructed and embedded within the discipline as well as within the norms and mores of the particular unit" in which the nurse practices.

In chapter 2, Dreyfus and Dreyfus review the western European philosophical tradition in their reconsideration of the currently prevalent belief "that the role of experience is merely to refine theory." They present their five-stage model of skill acquisition (known as "the Dreyfus model"), which includes the stages of novice, advanced beginner, competence, proficient, and expert. Separate chapters explore the four last stages. In chapter 7, Rubin closely examines a group of nurses who appeared not to develop professionally through the normal trajectory and whose practice was judged to be "safe but not expert" despite years of experience. Striking attributes of this group included lack of memory about patients, replacement of the right/wrong distinction by the legal/illegal distinction, and lack of any sense of clinical and ethical agency. Rubin finds fault chiefly in the structure of nursing practice and calls for improving nursing education so that skills specific to nursing are provided. Chapters 8 and 9 elucidate "the social embeddedness of knowledge" and "the primacy of caring and the role of experience, narrative, and community" in unifying clinical and ethical expertise. In chapter 10, Dreyfus, Dreyfus, and Benner critically appraise the "justice versus care" controversy raised by Lawrence Kohlberg's cognitivist model of moral development and Carol Gilligan's feminist critique of Kohlberg's levels with her "caring" situationist ethic based on intuition and responding with love. Coming down on the latter's "caring" side but finding her arguments inadequate, the authors flesh out the concept of moral maturity with reference to the traditional philosophy reviewed in chapter 2. Although they mention "Christian caring practices" in discussing Gilligan, the book as a whole does not explicitly consider religious perspectives, nor does it indicate sources for the nurses' beliefs or knowledge shared by communities.

The final three chapters address the nurse-physician relationship in terms of "negotiating clinical knowledge" and cite the implications of this relationship for basic nursing education, administration, and practice.

This new edition of Cameron's initial 1991 publication covers the continuing decline in moral and cultural vision and principled consensus, which are being ever more outstripped by rapid scientific/technological developments in the biosciences and the restructuring of health care delivery. The framework of "Christian Hippocratism," which constituted the mainstream Western medical tradition until recently, is again held up to assess the challenges and deficiencies in current medicine. Cameron stresses the complexity and positive future potential of the Hippocratic legacy, noting that this book is not itself about "Christian medicine."

Many new bioethics questions are fresh versions of the ancient vices of abortion and euthanasia (both of which are prohibited by Judeo-Christian values). With regard to the new challenges posed by managed care, one should ask to what degree the professional character of medical provision is aided or undermined by the way such care is financed or managed. While acknowledging that traditional medical models (such as "fee-for-service" with its emphasis on the individual physician), are not problem free, Cameron points out that professional character has not been considered adequately, if at all, in current debate. As the biosciences have become more corporate in nature, medicine has increasingly come to be viewed as a consumer product. Standing against this trend, Hippocrates remains "the patient's friend"?locking medical practice into "a common embrace" of the human and the divine?and "sets the sanctity and dignity of human life at center-stage."

Six chapters examine the Hippocratic legacy (including Christian, Jewish, and Muslim adaptations), the current status of the medical profession (sociological considerations), "Germany and Geneva" (Nazi medicine and international conventions), post-Hippocratism and the human community (ancient roots, consideration of the human embryo, and "Singerism" and "speciesism"), healing and suffering (the euthanasia debate), and a future for medicine (making a genuine Hippocratic paradigm shift). An appendix, "Towards a Theology of Medicine," is addressed to "good pagans" who appreciate the Hippocratic-Christian ethical inheritance as well as to Christians. The foreword from C. Everett Koop (former U.S. Surgeon General) and an introduction from Sir John Peel (past president of the British Medical Association) attest to the book's relevance to current professional practice.


Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine is intended for use not only by clinicians and students but also by hospital administrators, hospital attorneys, institutional ethics committee members, quality reviewers, and health plan administrators. It presents a four-topic matrix for quickly identifying issues in practice, as well as appropriate principles for resolving ethics problems (see box). The four-topic technique reflects the way clinicians analyze actual cases, with case study presentation following an approach familiar in medical education.
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<th>MEDICAL INDICATIONS</th>
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Originally written for physicians in internal medicine, the book has broadened its scope to adult medicine in general and then also to pediatrics (sections tagged with the letter P). Four clinical cases reappear throughout the book: "Mr. Cure" (24-year old man brought to the emergency room with appearance of pneumococcal pneumonia and pneumococcal meningitis), "Mr. Cope" (42-year-old man with insulin-dependent diabetes, controlled but possibly with complications), "Mrs. Care" (44-year-old married woman with multiple sclerosis, experiencing progressive deterioration and profound depression), and "Ms. Comfort" (58-year-old woman with breast cancer that has become metastatic).

The methods are not grounded in a religious perspective, with the authors commenting that "Western medicine has long maintained a distance from religion because of scientific skepticism about faith and the professional duty to avoid favoritism toward any religious position." However, the text stresses the complexity of the place of religion in medicine and considers its importance to both the practicing physician and the patient (two case examples are given). Beliefs due to religious and cultural diversity, treatment refusal on grounds of religious or cultural belief (one case), treatment refusal by minor children on grounds of religious belief (two cases), and parental decisions based on religious or cultural beliefs (four cases) are among the issues that receive attention. For hotly debated topics such as physician-assisted suicide, the authors present the pros and cons and describe the current medico-legal status without coming down on either side. With respect to issues such as resource allocation, the authors present alternative models and may provide a "Comment" and/or a "Recommendation."

In this second edition of his classic 1983 text, William May continues to examine images of the healer and also includes material on religion and health and on the controversy over correlating piety with good health and longevity. He appraises new developments in genetics and the expanded movements for assisted suicide and euthanasia and also considers the health care system and health care reform. A short index is included to help readers track additions to the first edition.

May works within a Christian framework and employs the metaphor of "corrective vision" to define the aims and scope of medical ethics. This metaphor may be traced back to Greek philosophy and to Calvin, who once called the Holy Spirit the "spectacles of faith." Moral reflection does not just scan the world or the professions as they are, "rather it entails a knowledgeable re-visioning of foundations and ends." This revisioning extends to reform of the health care system. Acknowledging divisions within the Church and other possible pitfalls, May makes a scripturally-based case for explicitly Christian engagement in health care reform (John 5:2-9, and Isaiah 61:1-2 as read by Jesus in the Gospel of John). According to May, restricting the Church's role to delivering corporal works of mercy (withdrawing altogether from the arena of politics) will diminish these scriptural themes.

Separate chapters are devoted to the images of parent, fighter, technician, covenanter, and teacher, each illustrated with commentary from philosophy and literature and with historical events and current controversies. Images do not function as neatly and crisply for case problem-solving as do principles, explains May. "Rather, they provide a comprehensive ordering of life?an interpretation of role, metaphysical setting, and institutional context?that makes moral behavior seem more like a rite repeated than a puzzle solved." The covenant concept in its deep biblical sense, as opposed to contract (which suggests legal rules and agreements), captures both the tie of medicine to the sacred and the ties between the patient and the healer. Growing "contractualism" has made harmful inroads into the covenant-based images of the healer.

May outlines what might be done in large-scale organizations to support the covenantal relationships and actions of individual healers and the health care team in the institutional setting. Although conflicts are unavoidable, "rightly understood, a covenantal ethic should help strengthen both institutional and collegial ties."

Orr, Robert D., and Fred Chay. Medical Ethics: A Primer for Students; A Small-group Study for Medical and Dental Students. Bristol, TN: Paul Tournier Institute, 2000.

A practicing physician/clinical ethicist and a theologian/medical ethics professor have developed an accessible primer to prepare Christian medical and dental students to integrate their faith and their profession. The book begins with the understanding that the Hippocratic/Judeo-Christian foundations of medical ethics are crumbling, and it provides the basic information, real texts, decision-making strategies, hypothetical clinical cases, questions and exercises, and spiritual counsel that students will need to make sense of their world and to develop as faithful, effective Christian clinicians. Established health care professionals and administrators also might find the primer useful as a personal and institutional assessment tool. The case illustrations involve organizational ethics (such as lying and financial conflicts of interest) as well as bedside clinical
This primer is designed to enable students to recognize three chief worldviews?atheism (a.k.a. naturalism), pantheistic monism (a.k.a. new age philosophy), and transcendent monotheism. Two major ethical archetypes?deontological (duty and rule based) and teleological (results oriented)?are set out. Ethics systems are catalogued, with exercise questions and scriptural citations clarifying differences between the ways Christians and various non-Christians arrive at their respective answers. Students are asked not only what they would do in given situations (such as observing a late-term abortion procedure) but what response they might expect from an "ethical subjectivist," a "conventionalist," a "situationalist," an "emotivist," an "utilitarian," an "unqualified absolutist," a "qualified absolutist," and a "graded absolutist." The requirements of being a professional and the challenges facing a partially-trained professional are illustrated with real codes, including the CMDA's oaths, the original Hippocratic/Judeo-Christian oath, and the AMA's Principles of Medical Ethics.

How to integrate standard ethics principles with Christian concepts is displayed in a "Principled Matrix for Decision-Making." At the center are Jonsen, Siegler, and Winslade's classic "four quadrants": medical indications, patient preferences, quality of life, and contextual features (see above). Interwoven with them are the related secular principles of non-malfeasance, autonomy, beneficence, and justice. A fifth principle of fidelity (faithfulness to the individual patient), taken from nursing ethics and often overlooked in secular medical ethics, should pervade all content and process steps, assert Orr and Chay. In the outside frame are the related Christian-scriptural principles?(1) truth-telling, non-exploitation; (2) free will, God's purpose, obedience, dominion, stewardship, faith, sovereignty; (3) Imago Dei, sanctity of life, contentment, compassion, service, meritorious suffering; and (4) mercy, grace, hope, eternity, scripture. A simplified five-step process represented by the acronym CARER?clarify, analyze, resolve, enact, and reassess?is provided for students as a decision-making framework. Extended hypothetical cases are presented for application of theory, with separate sessions devoted to patient preferences, quality of life, and contextual features (such as justice).

The concluding session is designed to help doctors use rather than misuse the Bible in ethical decision-making. Helpful strategies cited include Terrance Tiessen's principles to identify "trans-cultural absolutes," or universal norms, that go beyond a particular historical situation and can be applied in any age. Students are asked to conclude their course by writing their own Christian credo for their medical or dental ministry, attesting to what they believe as well as to what each belief requires them to do or not to do.


The authors of The Christian Virtues in Medical Practice build on the ethical obligations they set out in an earlier, companion volume, The Virtues in Medical Practice (1994). The question, "What difference does it make to be a Christian physician?," is addressed within a specifically Roman Catholic tradition of an ethics of virtue. The responses focus on what kind of person a Christian physician ought to be. The Christian virtues of faith, hope, and charity and the ethical principles of beneficence, autonomy, and justice are embodied in the Christian person. The concept of
"Christian personalism," as elaborated in the Christian anthropology of Pope John Paul II, shapes medical ethics in two specific ways: (1) professional ethics and the obligations of the Christian physician, and (2) problem-oriented ethics and certain specific ethical dilemmas involving human life. Fidelity to this personalist anthropology transforms the principles currently prevailing in secular medical ethics. Thus, beneficence becomes more than avoiding harm or preventing evil, and autonomy becomes more than the negative right to noninterference. In confronting the human/life issues, the truth about the human person is seen as the only safeguard against technological imperatives governed by the utility to be gained and costs to be saved.


The authors of *Called to Care: A Christian Theology of Nursing* build on their earlier collaboration, examining changing values within the nursing profession and continuing paradigm shifts. They assert that nurses cannot separate their professional roles from their profession of faith, and they find that the Christian faith is at the very heart of nursing theory and practice. The first of five sections reviews the revolution in the nursing paradigm, noting a resurgence of pagan worldviews and linkage of nursing practices with controlling "energy." A table displays key differences between "modern," "biblical," and "post-modern" worldviews. The other sections are organized around four components that must be considered in a working biblical worldview for nursing?*person, environment, health,* and *nursing.* The biblical understanding of shalom in health underpins a view that individuals, created by God with unique value and worth, are fulfilled in relationship with a human community.

Laced with anecdotes and vignettes to illustrate how various problems play out in practice, the book cites scripture to support maintenance of specific principles in its holistic, biopsychosocial, caring-centered vision and definition of the profession. The context of the Church as a center for health care, the authors believe, "will continue to expand as economically driven health systems leave people confused and underserved." Nurses conducting research should therefore be clear about the philosophical and theological underpinnings of the theories they use.

The book concludes with an appendix, "Guidelines for Evaluating Alternative Therapies," which provides questions for assessing potential religious and philosophical problems embedded in holistic alternative therapies such as meditation and centering.


The author?a Franciscan friar; physician; and scholar of philosophy, ethics, and health services research?offers considerations emerging from a retreat he conducted for physicians in January 1996. Sulmasy explains that this is not a book *about* spirituality but a book *of* spirituality in that the reflections have arisen out of his own personal experience of being "a man of faith engaged in the work of a health care professional." He asks where God may be found in the work of health care and where a Christian can lay claim to this work in the name of the kingdom of God.
Sulmasy intends to follow the mandate of Vatican II, which charges the laity to transform the world in the light of the gospel. He addresses his contemporary health care professionals in the context of an increased sense of meaninglessness in society, changes and pressures in health care that make that profession less satisfactory, and evidence of a deep hunger for things spiritual.

Spirituality is defined as "a description of one's relationship with God," though unbelievers professing a sense of spirituality are allowed to substitute another term for "God." Jesus is presented as the preeminent healer because He is in relationship with the transcendent Father. From a spiritual perspective, technical competence is necessary but insufficient for healing, which requires a recognition of the human face of each person in medical need. According to the author, both the healer and the healed "share a bond that ties them to each other through their humanity, their mortality, and the God-given spark of grace that lives in each of them."

Health care professionals are urged to cultivate their relationship with God, read the scriptures, and listen to what God has to tell them. Love and trust are examined as responses in situations of uncertainty arising in a rigid and scientific discipline that esteems proven facts. The "wine of fervent zeal" and the "oil of compassion," quoting St. Bonaventure on the gospel of the Good Samaritan, are proposed to address the current malaise in both nursing and medicine. "Reading" the patient as a "textbook" and seeing the presence of God can teach physicians and nurses spiritual, as well as medical, lessons. "The Christian clinician prays for patients, prays with patients, and prays the prayers of patients," attests Sulmasy. To break the taboo against expressing religious commitment in health care, the author reviews data showing that religion is important to patients. In providing guidelines for "God-talk at the bedside" in four different situations (according to belief or nonbelief in God by the health care professional and the patient), the author takes care to distinguish between the roles of practitioner and pastor. To respond adequately to the mystery of suffering in individual patients, the author asks practitioners to keep in mind that "infinitude is the message" and that illness is only the "messenger."


This book, authored by a nurse/clinical ethicist/health care consultant, is designed to help nurses examine selected contemporary health care issues from an ethical perspective. Readers are encouraged to interact with the material to enhance their ability to reason ethically and to strengthen their role as a patient advocate and effective caregiver. Uustal outlines a decision-making process drawing on elements from the nursing process, clinical medical analysis, deontological and utilitarian ethical theories, the valuing process, and Albert Jonsen's casuistry approach based on reasoning from cases. Readers are also taken through a neutral values clarification process, separate from any religious framework or absolute moral principles.

The author has developed hypothetical composites of her experiences as clinical cases for discussion, with questions at the end of each case to promote multidisciplinary group discussion. Additional theoretical details should be sought, as needed, from supplementary sources listed in separate bibliographies on values, moral judgment development, and bioethics. Real-text excerpts or summaries are provided for selected documents and codes, including the American
Nurses' Association Code of Nurses, the Patient Self-Determination Act, withholding/withdrawing treatment or nutrition/hydration (several organizations' positions), and ethical guidelines for pain management in care of the dying (from a physician-scholar's casebook). Professional issues, rights, and obligations reviewed include truth-telling, documentation of surgical complications, faith-based rejection of treatment or alternative medicine, handling of children's care, and handling of pregnant patients who appear ambivalent about abortion. Specific cases, listed in the detailed Table of Contents, are grouped under "Informed Consent, Refusal of Treatment and Competency," "Quality of Life, End of Life Decisions and Medical Futility," "Nutritional Support and Hydration," "Pain Management and Palliative Care," and "Euthanasia and Assisted Dying." Principle-based and care-based approaches are compared in a side-by-side table with respect to key features, moral methodology and case analysis, the health care professional-patient relationship, and implications for the health care professional.

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