September 2022

Ethics Dispatch

"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- Ludwig Wittgenstein

Hot Topic: The Ethics of Nursing Strikes

Nurses in Minnesota recently went on a historic strike. Over 15,000 nurses from 13 hospitals in Duluth and Minneapolis protested for three days, all while holding signs that read "Patients Before Profits," "Say it With Me: Safe Staffing," and "Unsafe Staffing Leads to Moral Suffering." This was the largest strike of private-sector nurses in U.S. history.

The strike was prompted by pay-wage disparities, nursing shortages and, as the picket signs suggest, controversial staffing practices. Staffing issues range from unbalanced nurse-to-patient ratios to assigning newer nurses tasks "typically held by more experienced nurses." Nurses are being asked, for instance, to take on patients needing equipment they "might not be trained to use," impacting patient care.

Chris Rubesch, a nurse at Essentia Health, writes:

I can't give my patients the care they deserve . . . . Call lights go unanswered. Patients should only be waiting for a few seconds or minutes if they've soiled themselves or their oxygen came unplugged or they need to go to the bathroom, but that can take 10 minutes or more. Those are things that can't wait.

Upon entering the nursing profession, many nurses pledge to promote the welfare of those committed to their care. But what if nurses, through no fault of their own, are unable to promote patient welfare? In the case of Minnesota, what if nurses lack the staffing resources they need to adequately meet the needs of their patients? Strikes in Minnesota and trends across the country suggest this is already happening and it's hurting patients.

Poor staffing practices also hurt nurses. In previous *Ethics Dispatches*, we've noted how scarce resources, questionable hospital policies and compromised standards of care can lead to moral distress. Moral distress, to be clear, captures instances in which a person *knows* the right thing to do, but feels coerced into doing something morally impermissible. In the case of Minnesota, nurses *know* it is right to provide proper care to their patients, but claim they are unable to do what they ought on account of unsafe staffing practices and policies. Tracey Dittrich, a nurse in Minnesota, notes:

There are shifts where you have three critically ill patients, and you have to decide which patient gets the care, or when . . . . I work with people all the time that go home every day and feel horrible because one child had to wait longer

for medication, or another child needed to wait longer for an IV. Another child maybe had to wait for a breathing treatment because we just couldn't get to them all fast enough.

Morally distressing situations like these have a non-trivial impact on nurses, causing apathy and discouragement. There is evidence also that moral distress leads to increased depression and anxiety among nurses.

Inadequate staffing has an impact on both nurses' well-being and that of their patients. It leads to mental health issues for nurses and then also to suboptimal patient care. Beyond the human costs, this is not good business practice. Practice managers and hospital administrators surely know this to be true. Why then do problems persist? Might the terminology of "moral distress" describe what at least some administrators are experiencing now also? In the midst of financial crises in healthcare, with a record number of hospitals closing, there would be two sides to every story reported in Minnesota and elsewhere. Both for nurses and those who employ them, ethics dilemmas abound.

Bioethics in the News

Healthcare Ethics Scholars Must Uphold Abortion Scholarship... Applying NFT's to Bioethics
HMS Bioethicists Awarded NIH Grant
From Voluntary to Mandatory Vaccinations for Cancer Patients

Case Study: Too litte, too late... almost

Angelie is a nurse in the ICU at a research hospital located in the heart of downtown.

The hospital has seen a surge in cases at various times since the start of the COVID-19 pandemic. Staff shortages and a general lack of hospital resources has led to high turnover rates and stress among the nursing staff, including Angelie.

She recently graduated from nursing school and comes from a long family tradition of nurses. Her father is a nurse and so was her grandmother. In fact, many of her cousins, aunts and uncles work in the medical field. At a young age, she was taught to value life and human dignity, that working as a nurse is a privilege and is a means of promoting these values. After graduation, Angelie was determined to hold herself and those around her to the highest possible nursing standards.

On this particular day, Angelie feels like she's failing. ICU beds are maxed out even though the COVID surge has long since passed. There are numerous active cases always, but it's more than just COVID. Perhaps some of what is happening now is partly the aftermath of COVID infections. No one knows for sure. What Angelie knows is that the hospital census is consistently pushing the limits of nursing resources, especially for critical care units, and her ICU is short-staffed yet again. Angelie is rushing from room to room and can't seem to get her head above water.

As she's monitoring ventilation support for one patient, Angelie notices other hospital staff rushing into the room of another of her patients. Her heart pounds while running down the hallway.

Mr. Randall—an 85-year-old male-identifying patient with a history of chronic lung disease—was admitted into the hospital a couple weeks ago with a severe case of COVID-19. Mr. Randall's health was on the upswing with hope of transferring out of the ICU. But he now has suddenly suffered a bout of acute respiratory distress, with dangerously low oxygen levels. Alarms in his room went off, but Angelie was so overwhelmed with the care of her other patients that she wasn't able to respond immediately. As a consequence, Mr. Randall is crashing and a resident physician had called a code blue.

Angelie is devastated. She had promised to provide the best care possible for her patients, including Mr. Randall. But now she had failed him. Her inattention was due not to lack of caring but to an insufficiency of care providers. Her unit is under-staffed and maxed out.

Mr. Randall survived. After a long shift and charting for an extra hour, Angelie reflects on how dangerously close her patient came to dying on her watch. It's hard not to blame herself, even though Angelie knows she was doing her best to provide the best care possible. She had wanted to tell Mr. Randall and his family how very sorry she was for how things had gone today. But what could she say? That doing "her best" had nonetheless placed her patient at death's door? That her hospital management had failed them both by not staffing adequately? Would there be a lawsuit coming?

Angelie is tired and losing motivation. She feels hopeless and is struggling to find the passion that led her to the nursing profession in the first place. She ponders quitting, doing something else with less stress, whether or not the pay is better. Many of her work colleagues have quit already. Others say they'll likely do so before the year is over. Angelie hasn't left nursing in part because it is so much a part of her family tradition. Yet she knows things cannot continue as they are. Mr. Randall's case is not an isolated incident, and she fears that without proper staffing support, patients like him will suffer needlessly and some will die.

Ethical Musings: What is Valuable & Why Does it Matter?

The philosopher/ethicist Julia Driver distinguishes between value theory and normative ethics. The former answers questions about the Good—what, if anything, is valuable? —while the latter answers questions about the Right—how should we approach the Good?

For many philosophers, theories of the Good inform theories of the Right. In other words, we can arrive at what our ultimate moral obligations are by first settling what is ultimately valuable. According to John Stuart Mill, for example, well-being is intrinsically valuable. We should approach this good by maximizing it, creating more of it.

These distinctions may seem arbitrary, but they are motivated by a deep concern for the *ultimate* foundations of ethical decision-making:

The creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure. (Mill, 1863)

Mill is *not* concerned at arriving at that which is instrumentally valuable, i.e., that which is valuable for achieving certain ends. Sandwiches are instrumentally valuable for relieving hunger. Money is instrumentally valuable for purchasing furniture or clothing. Neither of these things are valuable in and of themselves. Mill wants to arrive at what is *ultimately* valuable. He grounds his ethical theory in human happiness. In turn, and as the quote above suggests, happiness is interpreted as "the pleasant life" or the absence of pain. According to Mill, any *thing* we value—whether it's money, education or sandwiches—is valued because of the contribution it makes to human happiness.

Whether or not one accepts Mill's value theory, he gestures at philosophical questions that are crucial for navigating the ethical dimensions of the case study above and the nursing strikes in Minnesota. What if anything is valuable? What is being valued?

In the case of the Minnesota nursing strike, we might ask: What is being valued by hospital administrators in Minnesota relative to the values of striking nurses?

It seems nurses in Minnesota went on strike because they perceive that the well-being of patients and nurses are not being valued sufficiently by hospital administrators. If administrative values were in line with well-being, one would expect to see this reflected in staffing policies that assign adequate nurse-to- patient ratios. Nurses could be ensured of adequate training with complex technology requisite for safe and optimal patient care. Any apparent failure on an administrative level to promote as primary the organizational value of well- being can result in harms to patients like Mr. Randall in the case scenario above. Harms then are done also to conscientious nurses like Angelie by causing moral distress and feelings of depression and anxiety.

What *should* be valued in these cases? If we adopt Mills theory, it could be argued that healthcare systems in Minnesota and everywhere should value and prioritize in policies the well-being and happiness of patients and those who care for them. The happiness of hospital administrators and executives-- for example, by maximal executive level salaries and benefits--definitely should not be prioritized over the happiness of nurses and their patients. Where moral dilemmas arise for conscientious healthcare administrators is when the perceived or actual wellbeing and happiness of employee caregivers is weighed against the wellbeing of the organization's fiscal stability. Many good leaders in C-suites surely are also morally distressed in these times of economic instability for healthcare institutions.

Everyone's happiness is morally significant. Whether we adopt Kant's theory of value which values rational agency, or Aristotle's theory of value which prioritizes human flourishing, or Mill's theory of human happiness, one thing seems clear: value, and our orientation towards it, matters.

By Polo Camacho, Ph.D.and Tarris Rosell, Ph.D., D.Min.