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A major focus in discussion of ethical issues and dilemmas in the context of nursing is on the professional nurse in the hospital setting. The vast majority of nurses in the United States do practice in hospitals and nursing homes. Yet the majority of patients requiring nursing services receive health and medical care somewhere else in the health care system, e.g., physicians' offices, out-patient clinics, homes, health maintenance organizations, neighborhood health centers, work and school settings. As Williams points out, the orientation to the setting where care occurs is a limited definition of community health nursing as it focuses on individualistic clinical approaches to care of individuals and families and does not necessarily consider health needs of aggregates or articulation of acute and non-acute care institutional arrangements in the community.[1]

Community Health Nursing: Some Concepts

In order for nursing to be community oriented, it must consider the health needs of population groups or aggregates of individuals and ways of organizing the community to meet those needs. Individuals in an aggregate have one or more personal or environmental characteristcs in common, e.g., individuals with hypertension or elderly persons

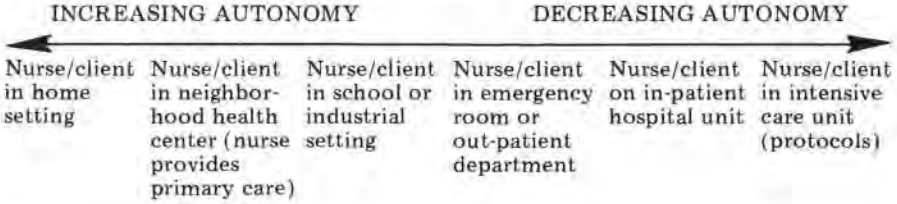
living alone.[2] This focus is generally not accounted for in community health nursing programs which perpetuate the episodic, patient-demand, and provider-response approach to care with few exceptions.

The notion of community is itself somewhat elusive to define since it may be used to connote emotional, structural or functional communities.[3] A structural community may be any aggregate of people or a geopolitical community. An emotional community is one where a person has a feeling of belonging or a special interest community, such as mothers working together for a safe recreational area for their children. A functional community is a community of identifiable need, for example, migrant workers. This last concept is somewhat more congruent with that of Williams, discussed earlier. Community nurses must actually be aware of all these communities in which they live and work to provide effective nursing services. People needing acute care services in a hospital setting might also be considered as another aggregate in looking at the structure of health care systems and the need for nursing services in a defined community.

This paper is limited to the more individualistic clinical approach as several of the ethical dilemmas fall into this narrower range with some dilemmas bridging both the individualistic and aggregate approaches to nursing care in the wider community. The ethical issues and dilemmas faced by nurses in the community may seem less exotic than those in the hospital setting where most of the advanced technologies are available and used. Yet community health nurses encounter a host of ethical dilemmas whether they work in more traditional community nursing agencies such as a visiting nursing association or in a neighborhood health center where they deliver primary care, e.g., examination for and detection of abnormalities and deviations from the norm.

Before looking at some of the specific ethical dilemmas encountered in community health nursing, the reader might wonder what some of the existing differences are in nursing within the hospital setting and in other community settings where nurses interact with patients and families. These differences may be viewed on a continuum of nurse-patient relationships based on settings and the hypothetical degree of nurse-patient autonomy in decision-making related to health and illness. See Figure 1.

Figure 1. Continuum of nurse/client relationships based on settings and hypothetical degree of nurse/client autonomy in decision making.



This continuum focuses on the individualistic clinical approach, recognizing that in reality much community health nursing practice still uses this orientation in providing service. Specific differences and variability are in such areas as: 1) boundaries of service, e.g., hospital unit versus community as defined for purposes of nursing service by an agency; 2) direct physical supervision and back-up, e.g., types of independent and dependent decision-making by the nurse and control of patient behavior by health professionals on a hospital unit versus a home or ambulatory care setting; and 3) different types of care coordination in a hospital versus the broader community where welfare and educational institutions are often involved. In community settings there is usually a broader focus on physical and mental health versus pathology and on the variables which affect health such as life style, adequate housing, and family interaction patterns. All of these variations on the continuum influence the dilemmas confronting the nurse and the nursing profession in specific decision-making settings.

Ethical Issues and Dilemmas

This paper elucidates some of the ethical dilemmas which the author has identified in discussions with nurses in various community health settings at both the policy-making level of decision-making and the individual nurse-patient-family level of decision-making about health and illness matters. Dilemmas which are situations with equally unattractive alternatives for choice, decision-making and action are discussed rather than issues *per se* which are points of debate and controversy between two or more parties. Although there is a variety of issues in health care ethics, it is usually the dilemmas involving the question, "What is the best or right thing to do?" which call forth some of the most agonizing thinking and discussion. For example, how should finite nursing, medical, and technical resources be allocated? Should they be allocated to individuals needing renal dialysis or to individuals needing physical and psychological health assessments? Who should make these decisions? What criteria should they use? How should those affected by a decision, both consumers and providers, be involved in the decision-making process? Does one consider quality of life and/or the right to life under any circumstances in the decision-making equation?

How are decisions justified on moral grounds, e.g., the greatest amount of good for the greatest number, or the use of some overriding moral principle, such as justice and/or beneficence? If one looks to moral principles for justifying decisions and actions, one should consider Rawls' five criteria for rightness of ethical principles. These criteria are: 1) universality, i.e., same principles must hold for everyone; 2) generality, i.e., they must not refer to specific people or situations, such as my mother or your marriage; 3) publicity, i.e., they

must be known and recognized by all involved; 4) ordering, i.e., they must somehow order conflicting claims without resort to force; and 5) finality, i.e., they may override the demands of law and custom.[4]

I do not make the claim that the ethical dilemmas discussed here are unique to community nursing but that they take on different dimensions for specific consideration by the decision-maker(s) at policy-making and individual interaction levels with the theoretical increase in patient and nurse autonomy. One might also hypothesize that one would find different dimensions in looking at ethical dilemmas posed by providing nursing service to various community aggregates whether they be pregnant teenagers or handicapped children. The gathering of a data base to identify aggregates needing nursing service will undoubtedly contain some additional ethical dilemmas for nursing.

Specific Ethical Dilemmas

One dilemma which occurs over and over at the policy-making level of community agencies where nurses are employed is use of nursing manpower resources for identified community health needs versus demand by particular population groups, such as those 65 and over where funding is provided by Medicare. Who is the agency's community(ies) for nursing care if one has a group needing pre- and post-natal nursing services, an ever-increasing caseload of clients over 65, and migrant workers in the same geopolitical community? With finite resources, what are agency obligations to each group? Should one provide some nursing service to all three groups on some moral principle of fairness and equity, or should one decide which group is the largest in number and has the greatest needs, a more utilitarian approach? Should actual and potential productivity of individuals in the group be considered in the decision-making equation?

The alternatives in this policy situation seem equally unattractive in the sense that not everyone can get needed nursing care because of finite resources. Can an agency justify providing care for some groups and not for others on the basis that funding is available for some groups? If the economic aspects are not considered, the agency may not remain viable in the community to provide nursing care for anyone. One readily sees in this situation how economic, social, political and moral aspects intersect in such a dilemma. One cannot begin to solve this dilemma without a data base identifying the health needs of the defined community and its aggregates. A community diagnosis is essential. Demand for service alone is not adequate as a basis for an ethically correct solution.

Another dilemma for community health nurses and agencies is the question of how far one should go in "protecting" people, such as the

mentally retarded who live and sometimes work in the community. This is an example of a specific dilemma which cuts across policy-making and the individual interactions of nurses and patients/clients. What is the obligation to a mentally retarded woman known to a community nursing agency who goes to work by herself on public transportation and is known to have been raped on her way home? If this woman becomes pregnant, does the community nurse in the home or neighborhood health center have an obligation to present alternatives, such as abortion and sterilization, to this woman and/or her family?

A third example of an ethical dilemma confronting the community health nurse is the right or best action one should take when child abuse is suspected in a home setting. In a situation where the nurse has spent a great deal of time and energy in developing rapport with a family, what does it mean to invoke the principles of beneficence (do no harm, do good), justice and respect for the individual in relation to suspected child abuse? Should one also consider the moral principle of veracity in this case? How does it apply? For whom? Should one consider these principles *before* reporting the situation to other designated community agencies? What factors does the nurse weigh in deciding what is the right or best thing to do? How does one justify this action? Do parents and children have equal rights in this situation? How can they best be protected? What should agency policy be if the problem of suspected child abuse is identified more frequently in one racial or ethnic group than in another?

The last example of an ethical dilemma in community health nursing is one faced by nurse practitioners in neighborhood health centers where they deliver primary care to patients. This dilemma is whether to take additional time for "caring and teaching" aspects of nursing care versus the need to see a fixed number of patients in order to make this type of nursing economically feasible for an agency. This may be the basic dilemma in the health professional-patient-agency triad. If one decides to base care on patient needs, how are finite resources allocated? What are the nurse's obligations to the individual patient and a group of patients? What are the obligations to the employing agency? Does the nurse have the "right" and obligation to deliver "minimal" physical care or to deliver "comprehensive" care which takes into account the physical, emotional, and social needs of the individual? In considering nurses' rights in delivering service, Fagin suggests that rights such as provision of an environment for professional nursing practice, appropriate economic rewards for same, participation in policy-making affecting nursing, and the rights to control professional practice within legal limits must all be actively exercised in settings where nurses practice.[5] If nurses combine the exercise of these rights with consideration of such moral principles as justice and beneficence,

for example, we may take one step closer to solving dilemmas involving accountability for care to patients so that nurses will not continue to agonize over this particular dilemma — not an easy, but a necessary step!

In summary, the ethical dilemmas discussed above have all surfaced in discussions with nurses in a variety of community health settings. Additional dilemmas were mentioned directly and indirectly, such as the inadequate health care received by the poor; care at home of the individual who does not have adequate housing, food, and other necessities; the individual whom the nurse believes does not have adequate medical supervision, e.g., chronically ill elderly, and the individual with unacknowledged drug abuse problems. The question was also raised regarding implications for safety of personnel, and individual choice about working hours when agency policies are changed, for example, providing nursing care in the evening. Many of these dilemmas represent both specific situations and broad social issues which providers and consumers must deal with cooperatively in a given community(ies). While variations on these dilemmas may also occur in the hospital setting, one can hypothesize that factors are weighed differently in the community setting. Their value depends on where the nurse and patient are located relative to the autonomy continuum, where the nurse-patient-family level of interaction occurs, and where policy is made. The two levels interface in the nurse delivering nursing service.

Research is needed to tease out the specific aspects of ethical dilemmas which differ for community nurses as they provide nursing services in the context of a variety of communities and community settings. However, nurses need not wait for research findings to develop networks for discussion of and steps toward resolution of ethical dilemmas already identified.

Structuring Ethical Dilemmas for Discussion and Action

In structuring an ethical dilemma for discussion purposes and steps toward resolution of what is the best thing to do, the following questions should be answered as completely as possible.

1. What is the proposed action or actions?
2. What are the probable consequences of the proposed action?
3. What is the intention or purpose of the proposed action?
4. What other alternatives or choices are available?
5. What is the setting or context of the proposed action?
6. Who are all the actors involved? What are their histories in relation to the dilemma under consideration?

This is one way to structure an ethical dilemma for consideration before action occurs. It provides one kind of data base and contains concepts familiar to nurses, that is, assessment and critical, reflective

thinking. An additional element is the factor of moral reasoning in justifying choices for action, e.g., consideration of the greatest good for the greatest number or the consideration of moral principles in terms of whether or not they are violated by particular alternatives for action. In moving to consideration of moral principles, such as justice, equality and respect for the individual, one is at what Kohlberg theorizes as the last or highest stage of moral reasoning. This goes beyond the previous stage of the social-contract, legalistic orientation which has utilitarian overtones.[6]

One might wonder if all ethical dilemmas are inevitable. Can some of our present ethical dilemmas in community health nursing be prevented? There may be such a thing as preventive ethics. If this is the case, we need to examine our present dilemmas and determine whether or not they could be prevented, for example, by more effective communication with all parties concerned. In the end, we are all consumers in relation to ethical dilemmas in delivery of nursing and health care anywhere in the community.

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