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# Capital Punishment; Series I; File 169

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#169 Statement Population At Risk

AMERICAN NURSES' ASSOCIATION

**Committee on Ethics**

**Statement on Nurses' Participation in Capital Punishment**

The goal of nursing is the promotion and restoration of health, the prevention of illness, and the alleviation of suffering. The social contract between the profession and the public is based on a code of ethical conduct that is grounded in the basic moral principles of fidelity to recipients of care and respect for life. These principles command a trust relationship between nurses and recipients of their care and avoidance of harm to the beneficiaries of nursing actions. Regardless of the personal opinion of professional nurses regarding the morality of capital punishment, it is a breach of the nursing code of professional conduct to participate either directly or indirectly in a legally authorized execution.

Recently adopted legislation providing for capital punishment by drug injection raises the possibility that some nurses may be asked to participate in the execution of prisoners by such activities as assessment, supervision, or monitoring of the procedure or the prisoner; procurement or preparation of the drugs or solution; insertion of intravenous equipment; or injection of the solution.

The ANA is strongly opposed to these and to all forms of participation by nurses in capital punishment.

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#169 Statement Population At Risk

# The Use of Rights Language: Rhetoric or Reality

Committee on Ethics
AMERICAN NURSES' ASSOCIATION

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#169

# Statement

# Population At Risk

This paper was prepared by the Committee on Ethics, American Nurses' Association.

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#169 Statement Population At Risk

## Preface

At its recent meetings, the American Nurses' Association Committee on Ethics identified the need to develop information relating to the use of *rights* language for reference by the various structural units. The committee indicated that the term *rights* is very complex and identified various points that deserve consideration.

These points included the following:

1. A right differs from a claim or privilege.
2. There are different levels of public policy, including (1) preference, (2) need, and (3) right; and questions arise when terms such as *right to health* and *right to health care* are used.
3. Legal rights differ from moral rights.
4. With every right, there is an attendant obligation, e.g. the patient has the right to determine parameters of care and the nurse has the obligation to give the best possible care.
5. An obligation carries no rights.
6. The concept of power is related to obligations: the nurse can be obligated only for those activities that she or he has the authority to do.
7. The Code for Nurses does not give nurses rights, only obligations.
8. Statements by ANA structural units should focus on obligations of the nurse and avoid rights language since the patient has no obligations to the nurse and the nurse has no rights, only obligations.
9. A nurse has certain rights as a person and these may conflict with obligations as a professional; this raises the question of whether one's personal value system overrides one's professional obligations.
10. Nurses may face dilemmas because they have legal rights as employees but only obligations and duties as professionals.
11. There is evidence that many nurses tend to shift their obligations to the employing institution.

The Committee on Ethics suggest that its publication, *Ethics in Nursing: References and Resources* be considered for further references regarding this subject.

The committee developed this statement to assist ANA structural units and constituent associations as they consider the use of rights language in their deliberations.

The Committee on Ethics
December 1979

#169 Statement Population at Risk

# THE USE OF RIGHTS LANGUAGE: RHETORIC OR REALITY

## Rights Language

Rights have been described as justified claims that individuals and groups can make upon others or upon society.[1] Society's unmet needs have often been expressed as society's rights. These expressions serve to denote values that the speaker believes should be acknowledged or affirmed in society. The term *right* may imply an obligation on the part of the speaker to attend to the right being affirmed, or it may be used symbolically. The symbolic use of rights language does not imply that the speaker (individual or group) has a specific attending obligation.

The symbolic use of rights language serves as an important political and social tool. It has been a part of many statements from governments, humanitarian organizations, international bodies, and professional organizations. These statements serve as social, economic, and political definitions regarding values and the establishment of policies to make the world a better place in which to live. For example, the United Nations has developed a statement of rights of children as a goal toward which all should work. This does not mean that the United Nations can or will be able to implement these rights. Implementation of rights expressed symbolically is complex, since such statements of rights may not be intended to be implemented immediately or by the body proposing them.

There is a tendency to view a right as an absolute value that cannot be overridden, regardless of the consequences. That is why the language of rights is so powerful today, in both the sociological and political realms. In reality, an absolute right usually exists only as a concept, and therefore rights should be viewed as contingent rather than absolute.

Rights can be either positive or negative. A negative right is the right to be free from constraint regarding a certain action. For example, to be free to decide whether or not to marry a certain person is an example of a negative right generally granted in our society. A positive right, on the other hand, refers to the claim that an individual makes on another individual or on society.

## Use of Rights Language by Organizations

Organizations whose concern is bettering the human condition have the obligation to make statements of rights and to develop the machinery to see that the rights expressed become realities or to act as a pressure group to have others implement those rights. Additionally, these organizations have the responsibility to make symbolic statements about rights that point to a long-term direction for change in the human condition. Problems arise when (1) rights statements that are meant to be implemented cannot be, and (2) rights statements made symbolically are interpreted as requiring immediate action.

The distinction between the symbolic use of rights language and statements of rights that imply obligations on the part of the speaker is especially important in relation to statements of rights made by organizations that give direction to professions. While rights language is a necessary part of the armamentarium of professional organizations, the members of the professions must recognize the intent of statements on rights made by their associations. Otherwise, the ideals expressed in such statements may produce guilt and frustration on the part of a professional when the rights expressed are not meant to be implemented immediately but are to be worked toward in various ways.

On the other hand, professional associations and their members must recognize the obligations they assume when they use rights language. Once rights are endorsed by a profession, it must move toward the goals so expressed. To paraphrase Thoreau, "It is necessary to build air castles, but it is also necessary to put foundations under them."

Likewise, the view of rights as contingent values rather than as absolutes must be understood in statements of rights made by professional associations. The ideal must be tempered with reality. Failure to recognize rights as contingent rather than absolute can lead to frustration for the member of a profession and the consumer of its services.

#169 Statement Population At Risk

## Nursing and Use of Rights Language

Historically, the nursing profession has considered itself the conscience of the health care system and has assumed a leadership role in championing the concerns of humanity. In this role, nursing, through its professional organization, has used rights language. For example, the American Nurses' Association's House of Delegates in 1970 passed the following resolution.

> **Resolution on National Priority**
>
> Whereas, The delivery of health care is not currently available to all citizens, and
>
> Whereas, Current fiscal allowances in the federal budget do not permit adequate delivery of health care, be it therefore
>
> Resolved, That (a) the ANA again emphasize its belief that quality *health care is a right* for all persons, not a privilege for the few, and continue to visibly support all measures to obtain this end, and that (b) the ANA vigorously pressure the government to redefine its priorities so that health care for its citizens be a first priority. [emphasis added][2]

In 1974, the ANA House of Delegates adopted a resolution on national health insurance that stated the following:

> Health, a state of physical, social and mental well-being *is a basic human right*, and . . . Government at all levels must act to insure that health care services are provided for all citizens. . . . [emphasis added][3]

The ANA House of Delegates reaffirmed this resolution in 1978 in a resolution that included the following language:

> The American Nurses' Association has for many years called for a national health insurance program that would guarantee to all people access to health care services of an acceptable quality *as a basic human right*, therefore be it . . . [emphasis added][4]

The right to health care is a contingent claim, because it inevitably requires a balancing of social interest and individual rights.[5] The claim of a right to health care is also a positive right, for it requires the provision of service by others if the claim or right is to be fulfilled.

In proclaiming health as a right of all, the American Nurses' Association has recognized that implementation of this right demands a realistic approach to government and other institutions in a position to effect access to adequate health care services for all. At the same time, nursing must recognize and fulfill the obligations it necessarily assumes in using such rights language.

Nursing groups, including structural units of the American Nurses' Association, may find the following questions useful when considering use of rights language.

1. Is this always a right under all conditions and in all circumstances (absolute)? Why or why not? If not, upon what is it contingent?
2. Under what, if any, circumstances should the right *not* be met?
3. If this right were implemented for everyone, what would the ramifications be, e.g. economic, social, political?
4. Whose obligation is it to fulfill this right? Why?
5. Does this right obligate the individual nurse? The nursing profession? Or society as a whole?
6. If this right functions for some, can it violate the rights of others? If so, should this happen?
7. What consequences occur if and when the right is *not* met?
8. What makes this a right? Law? Social norms? Customs? Religion?
9. What are the legal rights and ethical rights in this situation? Are they the same? Do they differ? Do they conflict?

#169 Statement Population At Risk

## The Code for Nurses and Rights Language

The Code for Nurses indicates the "profession's acceptance of the responsibility and trust with which it has been invested by society."[6] Upon entering the profession, a nurse therefore accepts the obligations corresponding to the responsibility and trust flowing to the profession from society. The code describes ethical conduct to be adopted by the nurse in fulfilling these obligations.

Three types of relationships are inherent in the Code for Nurses: the nurse-client, the nurse-profession, and the nurse-society relationships. The Code for Nurses does not speak to the employee-employer relationship. Employee-employer rights, duties, and obligations are determined by federal and state laws and are not unique to the profession of nursing; they are therefore not inherently defined by the profession of nursing.

Through the Code for Nurses, nursing has declared that the consumers of nursing services have rights: patients can make justified claims upon nurses. On the basis of the Code for Nurses, the nurse assumes duties and obligations to affirm and maintain those rights, such as the patient's right to privacy and to determine what will be done with his person.

No rights accrue to the nurse by reason of the assumption of the professional role. The profession itself does not grant any additional rights to its practitioners. A question often asked today is whether the nurse has any rights. Can a nurse make a justifiable claim of a patient? For example, does the nurse have a "right" to demand that the patient behave in a certain manner? By becoming a nurse, one does not lose any individual rights flowing from society; so, to that extent, a nurse has rights. But if the questions mean, does the nurse gain additional rights by becoming a professional, the answer must be no.

In summary, although the nurse as a person holds certain rights, the professional role entails obligations to clients, the profession, and society. These obligations are set forth in the Code for Nurses. Although the practice of each nurse will inevitably reflect individual beliefs and values that shape behavior and determine choice, the practice role is expected to be a professional role. It is the professional, not the person, that the client seeks for health care, and the treatment provided should be consistent with recognized professional values as expressed in the Code for Nurses and the Standards of Nursing Practice. Position statements by the profession should seek to clarify the obligations of the nurse and the ways in which such obligations can be met. The idealism of nursing should foster realistic approaches to problems, not rhetoric.

### REFERENCES


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AMERICAN NURSES' ASSOCIATION

**Statement on Health Care for a Population at Risk**

The American Nurses' Association Resolution on Sexual Life Style and Human Rights and the Code for Nurses speak broadly to civil rights and the rights for health care. However, at this time, there is continuing discrimination in health care experienced by members of the lesbian/gay minority population who constitute approximately 10 percent of the total population of this country. The need to address this human rights issue requires that the association respond immediately to assure the delivery of quality health care to this population. Inasmuch as there is widespread social stigmatization of lesbian and gay persons, members of this group often fail to seek health care, or when seeking care, find themselves socially vulnerable -- ostracized and punished.

While there are other health problems and concerns specific to this population which deserve attention, the most urgent at this time is Acquired Immune Deficiency Syndrome. The data indicates there is an incidence rate of Acquired Immune Deficiency Syndrome that is of epidemic proportions (4,000 reported cases as of June 1984). While AIDS affects persons with hemophilia and persons of Haitian origin, and persons who abuse intravenous drugs, over 70 percent of reported AIDS cases are either homosexual or bisexual men. In addition, the incidence rate has doubled every six months since the first reported case (1981) and the mortality rate is 40 percent after one year, 60 percent after two years, and over 80 percent approaching three years. The mortality and incidence rates of all reported AIDS cases surpasses that of Toxic Shock Syndrome and Legionnaires Disease.

Although the Department of Health and Human Services announced in June 1983 that AIDS was the "number one health priority," the federal response to this problem has been less than adequate. Funding levels for research have been inadequate with funding requests being delayed; and appropriations vetoed by the current administration. Furthermore, much of the funding available to meet the AIDS crisis was also sought by other important disease control programs in a time of constricting federal budgets. It is significant to note that early and substantial funding was provided for prompt research and treatment of other public health emergencies such as Toxic Shock Syndrome and Legionnaires Disease.

The American Nurses' Association believes that (1) the lesbian/gay population has a right to quality health care; (2) the lesbian/gay population has the right to have equitable attention to, and funding for, research related to health problems for which it may be at risk; (3) all people who have AIDS have a right to equitable and humanistic health care. These rights include (a) quality treatment, including nursing and social support services, (b) non-discriminatory use of current isolation procedures, (c) full explanations of research procedures, treatments and risks involved, (d) informed choice of treatment/research modalities, (e) confidentiality of the medical record, and (f) respect for privacy and significant relationships.

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