

Ethics in Professional Nursing Practice

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Nursing is a profession that has its own code of conduct, its own philosophic views, and its own place in the health care team. . . .Nurses work under their own license. That means that nurses are completely responsible for their work.

—JANET R. KATZ, 2007, *A CAREER IN NURSING: IS IT RIGHT FOR ME?*, p. 105

OBJECTIVES



After reading this chapter, the reader should be able to:

1. Distinguish between nursing ethics, medical ethics, and bioethics.
2. Delineate key historical events that led to the development of the current American Nurses Association (ANA) and International Council of Nurses (ICN) codes of ethics for nurses.
3. Discuss examples of professional nursing boundaries and ways that boundary crossings can occur.
4. Examine the ethical nurse qualities discussed in the ANA and ICN codes (see also Appendices A and B).
5. Contrast moral distress from moral integrity.
6. Recall ways a nurse can discern whether another nurse's character fits Aristotle's description of the truthful sort.
7. Define truth-telling in terms of two ethical frameworks: deontology and a virtue ethics approach.
8. Examine the ethical implications of caring for a dying patient whose physician exercised therapeutic privilege by not disclosing the whole truth.
9. Describe examples of scenarios that would prompt a nurse to respond with moral courage.

10. Compare patient advocacy and power in relation to nurses' everyday ethical work.
11. Formulate a plan for assessing a culturally diverse patient who is a new admission to a hospital unit.
12. Characterize two types of relationships: the nurse–physician relationship and the nurse–nurse relationship.
13. Weigh nurses' use of social networking in terms of professional ethical considerations.

Introduction to Nursing Ethics

Bioethical issues are relevant to nurses' work in everyday practice, but in matters of bioethics nurses usually are not autonomous decision makers. Nursing ethics, as a unique field, continues to be debated. Fry, Veatch, and Taylor (2011) continue to support the view that both nursing ethics and medical ethics are valid subcategories of the larger field of bioethics. Additional views are that everyday ethical practice in nursing is situated within an interdisciplinary team and that nursing ethics is distinctive from other disciplines in bioethics but is not yet unique (Volker, 2003; Holm, 2006; Wright & Brajtman, 2011).

The experiences and needs of practicing nurses, along with explorations of the meaning of nursing ethics, are areas of emphasis in nursing ethics. Johnstone (2008) defined **nursing ethics** as “the examination of all kinds of ethical and bioethical issues from the perspective of nursing theory and practice, which, in turn, rest on the agreed core concepts of nursing, namely: person, culture, care, health, healing, environment and nursing itself” (p. 16).

Johnstone's definition of nursing ethics is consistent with a common view that a strong bond between nursing ethics and nursing theory distinguishes nursing ethics from other areas of healthcare ethics. Nurses' professional relationships to patient care and within the healthcare team bring about ethical issues unique to the nursing profession. To practice nursing ethically, nurses must be sensitive enough to recognize when they are facing seemingly obscure ethical issues in everyday work.

Professional Codes of Ethics in Nursing

Professional nursing can be traced to England in the 1800s, to the school that was founded by Florence Nightingale, where profession-shaping ethical precepts and values were communicated. By the end of the 1800s, modern nursing had been established, and ethics was becoming a discussion topic in nursing. The Nightingale Pledge of 1893 was written under the chairmanship of a Detroit nursing school principal, Lystra Gretter, to establish nursing as an art and a science. Six years later, in 1899, the International Council of Nurses (ICN) was established and became known as a pioneer in developing a code of ethics for nurses.

By the turn of the 20th century, the first book on nursing ethics, titled *Nursing Ethics: For Hospital and Private Use* (1900), had been written by an American nurse leader, Isabel Hampton Robb. In Robb's book, the titles of the chapters were descriptive of the times and moral milieu, such as Chapter 4: The Probationer, Chapter 7: Uniform, Chapter 8: Night-Duty, and Chapter 12: The Care of the Patient (nurse–physician, nurse–nurse, nurse–public relationships). The focus in the nursing code initially was on physicians, because, typically, male physicians trained nurses in the Nightingale era. Nurses' technical training and obedience to physicians remained at the forefront of nursing responsibilities into the 1960s. This emphasis was reflected in the ICN *Code of Ethics for Nurses* as late as 1965. However, by 1973, the ICN code reflected a shift in nursing responsibility from a focus on obedience to physicians to a focus on patient needs, where it remains to this day.

American Nurses Association's Code of Ethics for Nurses

"A Suggested Code" was published in the American Journal of Nursing (AJN) in 1926 by the American Nurses Association (ANA), but was never adopted; in 1940 "A Tentative Code" was published in AJN, but again was never adopted (Davis, Fowler, and Aroskar, 2010). The ANA adopted its first official code in 1950. Three more code revisions occurred before the creation of the interpretative statements in 1976.

The word "ethics" was not added to the title until the 1985 code was replaced with its sixth and latest revision in 2001. Within the code are nine moral provisions that are nonnegotiable with regard to nurses' work. Detailed guidelines for clinical practice, education, research, administration, and self-development are found in the accompanying interpretive statements of each provision (see Appendix A for the ANA *Code of Ethics for Nurses with Interpretive Statements*).

A clear patient focus in the 2001 code obliges nurses to remain attentive and loyal to each patient in their care, but nurses must also be cognizant of ethical issues and conflicts of interest that potentially have a negative effect on patient care and relationships with patients. Other forces to be reckoned with in today's environment are the politics in institutions and cost-cutting strategic plans (see Box 3.1).

In the code, the ANA (2001) emphasized the need for the habitual practice of virtues such as wisdom, honesty, and courage, because these virtues reflect a morally good person and promote the values of human dignity, well-being, respect, health, and independence. Values in nursing emphasize what is important for the nurse personally and for patients. The ANA emphasized the magnitude of moral respect for all human beings, including the respect of nurses for themselves. **Personal regard** involves nurses extending attention and care to their own requisite needs, as nurses who do not regard themselves as worthy of care usually cannot fully care for others. Recognizing the dignity of oneself and of each patient is essential in moral reasoning. There are other statements in the code about **wholeness of character**, which pertains to recognizing the values of the nursing profession and one's own authentic moral values, integrating these belief systems, and then expressing them appropriately.

BOX 3.1 ETHICAL FORMATIONS: CODE OF ETHICS APPLICATION

In the *Code of Ethics for Nurses with Interpretive Statements*, the ANA currently emphasizes the word "patient" instead of the word "client" in referring to the recipients of nursing care. Do you agree with this change? Please explain your rationale for your answer.

Take a few minutes to review the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) in Appendix A. In your view, should there be additional provisions of the code? Would you remove any of the nine provisions? Please explain your rationale for your answers.

After reviewing the interpretive statements in the code, discuss random brief scenarios on how nurses can justify their actions with the following approaches or frameworks: the principles of autonomy, beneficence, nonmaleficence, and justice; Kant's categorical imperatives based on deontology; a utilitarian framework; a virtue ethics approach; and an ethic of care approach.

International Council of Nurses' Code of Ethics for Nurses

In 1953, the ICN adopted its first code of ethics for nurses. (See Appendix B for the 2006 ICN *Code of Ethics for Nurses*.) The multiple revisions illustrate a reaffirmation of the code as a universal global document for ethical practice in nursing. The four major elements contained in the code involve standards related to nurses and people, practice, the profession, and coworkers. The elements in the code form a framework that must be internalized before it can be used as a guide for nursing conduct in practice, education, research, and leadership.

Common Thread between American Nurses Association and International Council of Nurses Codes

A common theme between the ANA (2001) and ICN (2006) codes is a focus on the importance of compassionate patient care aimed at alleviating suffering. Nurses are to support patients' self-determination and are to protect the moral space where patients receive care. The interests of various nursing associations and healthcare institutions must not be placed above those of patients. Nurses are to uphold the moral agreement that they make with patients and communities when they join the nursing profession. Nursing care includes the primary responsibilities of promoting health and preventing illness, but the primacy of nursing care has always involved caring for patients who are experiencing varying degrees of physical, psychological, and spiritual suffering.

Professional Boundaries in Nursing

Professional ethical codes serve as useful, systematic, normative guidelines for providing direction and shaping behavior. The ANA and ICN codes apply to all nurses regardless of their role, although no code can provide a complete and absolute set of rules free of conflict and ambiguity—a rationale often cited in favor of the use of virtue ethics as a better approach to ethics (Beauchamp & Childress, 2009).

Some people contend that nurses who are without a virtuous character cannot be depended on to act in good or moral ways, even with a professional code as a guide. In the 30th-anniversary issue in 2006 of the *Journal of Advanced Nursing*, the editors reprinted and revisited a 1996 article by Esterhuizen titled, “Is the Professional Code Still the Cornerstone of Clinical Nursing Practice?”, and solicited three responses. One respondent, Tschudin, agreed with Esterhuizen that nursing lacks opportunities for full autonomy in moral decision making. There is abundant ground for nurses to engage in moral decisions, but they still do not have enough opportunity to participate. In the current uncertain moral landscape, nurses often wonder about the benefit of codes of ethics. Tschudin’s key message was that virtuous nurses with full autonomy and accountability have an internal moral compass to guide their practice and do not necessarily need a code of ethics.

However one perceives the value of the codes of ethics for nurses, they still serve as mandates for accountability in practice. Professional boundary issues occur in all settings of nursing. **Professional nursing boundaries** are commonly defined as limits that protect the space between the nurse’s professional power and the patient’s vulnerabilities. Boundaries facilitate a safe connection in a relationship, because they give each person in the relationship a sense of legitimate control, whether the relationships are between the nurse and patient, the nurse and physician, the nurse and administrator, or nurse and nurse. **Boundary crossings** or violations are actions that do not promote the best interest of the other person(s) in a relationship; crossings pose a potential risk, harm, or exploitation to the other(s) in the relationship. The blurring of boundaries between persons in a relationship is often subtle and unrecognizable at first. The ANA (2001) included numerous boundary issues in the code. See Box 3.2 for a few examples of these boundary topics and moral obligations.

Qualities of Ethical Nurses

Numerous qualities, or virtues, could describe the ideal ethical nurse. The foremost quality, often considered the fiber for all others, is moral integrity. Some people believe that moral integrity is necessary for the individual as a whole to flourish. A person with moral integrity usually is described as having honesty, truthfulness, trustworthiness, courage, benevolence, and wisdom. In this section, there is a discussion of (1) moral integrity—honesty, truthfulness, and moral courage; (2) concern—advocacy and power; and (3) culturally sensitive care. Other qualities, such as respect for others and confidentiality, are explored in the previous chapter.

Moral Integrity

Moral integrity represents a person’s wholeness of character. T. G. Plante (2004) stated that although no one is mistake free, people with moral integrity follow a

BOX 3.2 ETHICAL FORMATIONS: PROFESSIONAL BOUNDARIES AND MORAL OBLIGATIONS FOR NURSES AS SPECIFIED BY THE ANA *CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS (2001)*

Clinical Practice Boundaries

- Respecting patients' dignity
- Right to self-determination
- Delegating tasks appropriately
- Practicing good judgment
- Accepting accountability in practice
- Alleviating suffering
- Being attentive to patients' interests
- Working within the nurse practice acts and nursing standards of practice

Professional Practice Boundaries

- Maintaining authenticity in all relationships with others, such as nurse-to-nurse relationships, nurse-physician relationships, nurse-to-patient relationships, and multidisciplinary collaboration
- Addressing and evaluating issues of impaired practice; fraternizing inappropriately with patients or others; accepting inappropriate gifts from patients and families; confidentiality and privacy violations; and unhealthy, unsafe, illegal, or unethical environments

Self-Care and Self-Development Boundaries and Obligations

- Participating in self-care activities to maintain and promote moral self-respect, professional growth and competence, wholeness of character in nurses' actions and in relationships with others, and preservation of integrity
- Advancing knowledge and research through professionalism, practice, education, and administrative contributions
- Collaborating with other healthcare professionals and the public to promote community, national, and international efforts
- Promoting healthy practices in the community through political activism or professional organizations by addressing unsafe, unethical, or illegal health practices that have the potential to harm the community

moral compass and usually they do not vary by appeals to act immorally. Most of the time, when people speak of a person's moral integrity, they are referring to a person's quality of character.

People with moral integrity pursue a moral purpose in life, understand their moral obligations in the community, and are committed to following through without any constraints imposed on them by their moral stance. In a qualitative study on moral integrity by Laabs (2011), nurses' perceptions of the definition of **moral integrity** were, "[A] state of being, acting like, and becoming a certain kind of person. This person is honest, trustworthy, consistently doing the right thing and standing up for what is right despite the consequences" (p. 433).

Features of moral integrity include good character, intent, and performance. Nurses with moral integrity act consistently with personal and professional values. When nurses are asked or pressured to do something that conflicts with their values, such as to falsify records, deceive patients, or accept verbal abuse from others, moral distress may occur. In a healthcare system often burdened with constraints of politics, self-serving groups or interests, and organizational bureaucracy, threats to moral integrity can be a serious pitfall for nurses. When nurses with moral integrity must compromise, the compromise usually does not interfere with their personal or professional values. To have moral integrity means that a person's character is made of up several virtues; three of those virtues are honesty, truthfulness, and moral courage.

Moral Distress

Moral distress occurs when nurses or other healthcare professionals have multiple or dual expectations and cannot act according to the guidance of their moral integrity. Jameton (1984) popularized and defined the term **moral distress** as occurring “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Nurses' work involves hard choices that sometimes result in avoidance of patients, emotional and physical suffering, painful ambiguity, contradiction, frustration, anger, and guilt. Since Jameton's initial work, authors have continued to research and develop the conception of moral distress.

Numerous scholars have linked moral distress to incompetent or poor care, unsafe or inadequate staffing, overwork, cost constraints, ineffective policy, futile care, unsuccessful advocacy, the current definition of brain death, objectification of patients, and unrealistic hope (e.g., Corley, 2002; Corley, Minick, Elswick, & Jacobs, 2005; Pendry, 2007; Schluter, Winch, Holzhauser, & Henderson, 2008; McCue, 2011). Moral distress is defined in the context of institutional constraints. Research has revealed that nurses' work environments have a strong effect on the degree of moral distress experienced (e.g., Redman & Fry, 2000).

Leaders of nursing continue to search for strategies to reduce moral distress and promote healthy work environments. The American Association of Critical-Care Nurses (AACN) published a position statement to accentuate the seriousness of moral distress in nursing:

Moral distress is a critical, frequently ignored, problem in healthcare work environments. Unaddressed it restricts nurses' ability to provide optimal patient care and to find job satisfaction. AACN asserts that every nurse and every employer are responsible for implementing programs to address and mitigate the harmful effects of moral distress in the pursuit of creating a healthy work environment. (American Association of Critical Care Nurses [AACN], 2008, p. 1)

The AACN ethics work group developed a call-to-action plan—*The Four A's to Rise above Moral Distress*—for use by nurses to identify and analyze moral distress (AACN, 2004):

Ask appropriate questions to become aware that moral distress is present.

Affirm your distress and commitment to take care of yourself and address moral distress.

Assess sources of your moral distress to prepare for an action plan.

Act to implement strategies for changes to preserve your integrity and authenticity.

Honesty

In the 2010 Gallup poll, just as it had been over the past 11 years, nurses were rated as the most honest and ethical health professionals (Jones, 2011). Nurses continue to be ranked consistently as the most trusted voice among the healthcare professionals; nurses have earned this trust because of their commitment and loyalty to their patients. According to Laabs (2011), nurses voiced that being honest was important for three reasons: (1) honesty is a prerequisite for good care, (2) dishonesty is always exposed in the end, and (3) nurses are expected to be honest.

In a phenomenological study of nurses on honesty in palliative care, Erichsen, Danielsson, and Friedrichsen (2010) stated that nurses had some difficulty defining honesty. In an attempt to clarify their perception of honesty, nurses often defined lying or dishonesty as sharp contrasts to honesty. Nurses perceived honesty as a virtue related to facts, metaphors, ethics, and communication, while perceiving truth-telling as a palpable feature in trusting relationships.

Honesty, in simple terms, can be defined as being “real, genuine, authentic, and bona fide” (Bennett, 1993, p. 597). Honesty is more than just telling the truth: it is the substance of human relationships. It involves people having the ability to place emphasis on resolve and action to achieve a just society by exercising a willingness to dig for truth in a rational, methodical, and diligent way. A person with maturity in honesty will place bits of truths into perspective and prudently search for the missing truths before addressing the issue. In other words, honesty is well-thought out and rehearsed behavior that reflects commitment and integrity.

There are many ways that nurses can portray honesty. For example, nurses must stay committed to their promises to patients and follow through with appropriate behaviors, such as returning to patients’ hospital rooms, as promised, to help them with certain tasks. If nurses do not follow through with their commitments, trust may be broken, and patients potentially will see those nurses as dishonest or untrustworthy.

Honesty is also about being honest with one’s self. For example, if a nurse was in the process of administering medications and a pill fell on the hospital floor, would the nurse be justified in wiping it off and placing it back in the cup if no one was there to see the action? Nurses might be tempted to wipe off the pill and administer it just to keep from completing a required form for a replacement medication, but if nurses evaluate their problems and make decisions based on the thought “always be honest with myself,” it is more likely that they will make rational, trustworthy decisions regarding the care of patients.

Truthfulness

Aristotle recognized truthfulness as the mean between imposture (excessiveness) and self-deprecation (deficiency) and as one of the 12 excellences (virtues) that he identified in his book *Nicomachean Ethics* (Aristotle, 2002, C. Row Trans.). People accomplish their ultimate goal of happiness only by exercising rational and intellectual thinking, which is known as wisdom or contemplation. Aristotle explained his view of a truthful person as being **the truthful sort** (see Box 3.3).

Based on the principle of veracity, truthfulness is what we say and how we say it. **Truthfulness**, translated to “truthtelling” in the healthcare environment, means that nurses are usually ethically obligated to tell the truth and are not intentionally to deceive or mislead patients. Because of the emphasis in the Western world on patients’ right to know about their personal health care, truthtelling has become the basis for most relationships between healthcare professionals and their patients (Beauchamp & Childress, 2009). In the older, traditional approach, disclosure or truthtelling was done with more of a beneficent or paternalistic approach and involved basing actions on answers to the questions such as, “What is best for my patient to know?”

The ethical question to ask is: Are there ever circumstances when nurses should be ethically excused from telling the truth to their patients? The levels of disclosure in health care and the cultural viewpoints on truthtelling create too much foggi-ness for a clear line of distinction to be drawn between nurses telling or not telling the truth. The ANA *Code of Ethics for Nurses* (2001) obligates nurses to be honest in matters involving patients and themselves, and to express a moral point of view when they become aware of unethical practices.

In some Western cultures, such as the United States, autonomy is so valued that withholding information is unacceptable. Under this same autonomy principle, it is assumed that patients also have a right not to know their medical history if they so desire. Some cultures, such as those in several Eastern countries, do not prize autonomy in this way; the head of the family or the elders usually decide how much and what information needs to be disclosed to the family member as patient.

BOX 3.3 ETHICAL FORMATIONS: ARISTOTLE’S “THE TRUTHFUL SORT”

“We are not here talking about the person who tells the truth in the context of agreements, or anything of that sort . . . but about contexts in which . . . a person is truthful both in the way he talks and in the way he lives, by virtue of being such by disposition. Someone like this would seem to be a decent person. For the lover of truth, since he also tells the truth where it makes no difference, will tell the truth even more where it does make a difference; for there he will be guarding against falsehood as something shameful, when he was already guarding against it in itself. Such a person is to be praised.”

Source: Quotation from Aristotle. (2002). *Nicomachean ethics*. (C. Rowe, Trans.) New York, NY: Oxford University Press.

Therapeutic Privilege

The American Medical Association (AMA, 2006) published a statement on the definition of **therapeutic privilege** and offered an explanation of its moral meaning. The following excerpt spotlights this opinion:

[T]he practice of withholding patient medical information from patients in the belief that disclosure is medically contraindicated is known as therapeutic privilege. It creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully. Therapeutic privilege does not refer to withholding medical information in emergency situations, or reporting medical errors.

Withholding medical information from patients without their knowledge or consent is ethically unacceptable. Physicians should encourage patients to specify their preferences regarding communication of their medical information, preferably before the information becomes available [but] physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy . . .

All information need not be communicated to the patient immediately or all at once; physicians should assess the amount of information a patient is capable of receiving at a given time, delaying the remainder to a later, more suitable time, and should tailor disclosure to meet patients' needs. (para. 1, 2, 3)

When physicians exercise this privilege, they base their opinion on facts gathered from the patient's records and their interactions with the patient, family, and other healthcare professionals. There are several reasons nurses or physicians might avoid telling the full truth: (1) they are trying to protect patients from sad and heart-breaking news, (2) they do not know the facts, or (3) they state what they know to be untrue about the situation rather than admit everything they know to be true.

There are advantages for physicians and nurses to tell the truth, especially when patients are in advanced stages of a diagnosis (Loprinzi et al., 2010). With the full knowledge of the disease process, patients will make fully informed decisions, be prepared for the outcomes, have more meaningful dialogue with family members, and make the most of meaningful events during their remaining life. Physicians and nurses are left with a difficult decision to make, especially when a patient wants to know the full truth and physicians have decided to disclose only part of the truth—or none of it—to the patient. No matter how disappointing the news will be to patients and families, nurses must evaluate each situation carefully with wisdom and contemplation before making any decision on the degree of disclosure. A clear understanding of the communication that has transpired between the physician and patient and family members contributes to the nurse's decision on the degree of shared disclosure (see Box 3.4).

An excellent example of truth-telling is from the play *Wit* by Margaret Edson, winner of the 1998 Pulitzer Prize; the play was published as a book, then in 2001 was made into an HBO Home Movie and is available for purchase. Susie Monahan, R.N., decided to tell the truth to and be forthright with a patient despite a few physicians who chose not to do so (see Box 3.5).

BOX 3.4 ETHICAL FORMATIONS: A WOMAN WITH UTERINE CANCER

You are caring for a woman scheduled for a hysterectomy because of uterine cancer. Her surgeon is known to have a bad surgical record in general, but especially in performing hysterectomies. The woman has heard gossip to this effect and asks you about it before her surgery because she is apprehensive about using that surgeon. You know for a fact that at least one legal suit has been filed against him because you personally know the woman involved in the case—a botched hysterectomy.

Your choices are: you could be brutally honest and truthful with your preoperative patient, you could give her part of the truth by giving her information that you know to be untrue about certain gossip or not confirming the truth about certain gossip, or you could be totally untruthful by remaining silent or by telling her that you have heard nothing.

Discuss these options and any other ideas that you may have in regard to this case. As a nurse who wants to be committed to an ethical nursing practice, what actions might you consider in this difficult circumstance? Be as objective as possible.

Now that you have determined possible actions, please justify these actions by applying either Kant's deontological theory or a virtue ethics approach.

Describe the major differences, or any similarities, between these two frameworks (deontology versus virtue ethics).

Other than simply verbally telling the truth to patients and others, how else can you display honesty in ethical nursing practice? Think of how you would portray honesty in different settings and situations—bedside nursing of patients, documentation, dealing with coworkers, and administration—while taking into consideration the ANA *Code of Ethics for Nurses with Interpretive Statements*.

Moral Courage

Without moral courage, our brightest virtues rust from lack of use. With it, we build piece by piece a more ethical world.

—RUSHWORTH M. KIDDER, “A WHITE PAPER,” *INSTITUTE OF GLOBAL ETHICS*

Moral courage is having the courage to be moral (Kidder, 2005). Although defined in several ways, Kidder associated five core values with moral courage: honesty, respect, responsibility, fairness, and compassion. In a hermeneutical analysis of nurses in advanced practice, Spence and Smythe (2007) found that courage is an individual and a collective phenomenon that occurs in everyday practice. From the findings, Spence and Smyth stated that **courage** “can be seen as a response to threat or challenge, real in the present, recognized in the past, and/or anticipated in the future” (p. 52).

Having moral courage means that a nurse overcomes fear by confronting an issue head on, especially when the issue is a conflict of the nurse's core values and beliefs. **Moral courage** is having the will to speak out and do the right thing even when constraints or forces to do otherwise are present. Moral courage turns principles into actions. When nurses have the courage to do what they believe is the

BOX 3.5 ETHICAL FORMATIONS: SUSIE MONAHAN, R.N.: WIT—TRUTHTELLING

Susie Monahan was a registered nurse who was caring for Vivian Bearing, a dying patient with cancer, at a large research hospital. Vivian was getting large doses of cancer chemotherapy without any success of remission—in fact, the cancer was progressing at an alarming rate. She was near death but the research physicians wanted to challenge her body with chemotherapy for as long as possible to observe outcome effects. Everyone on the medical staff had been cold and technically minded, and no one had shown any concern for her except for Susie. Vivian had not been informed about the chemotherapy failure, her prognosis, or that she was dying. One night, Susie found Vivian crying and in a state of panic. Susie first helped to calm her, then shared a popsicle with Vivian at the bedside while she disclosed the full truth to Vivian about her chemotherapy, her prognosis, her choices about Code Blue or DNR, and her imminent death. Susie affectionately explained:

You can be “full code,” which means that if your heart stops, they’ll call a Code Blue and the code team will come and resuscitate you and take you to Intensive Care until you stabilize again. Or you can be “Do Not Resuscitate,” so if your heart stops we’ll . . . well, we’ll just let it. You’ll be “DNR.” You can think about it, but I wanted to present both choices . . . ” (p. 67).

Susie felt an urge to be truthful and honest. By giving human respect to Vivian, Susie was showing her capacity to be human.

Source: Edson, M. (1999). *Wit*. New York, NY: Faber & Faber.

right thing in a particular situation, they make a personal sacrifice by possibly standing alone, but will feel a sense of peace in their decision. When nurses are in a potential risk of danger, they need moral courage to act according to their core values, beliefs, or their moral conscience. Nurses are susceptible to experiences of apprehension and fear because of the uncertainty in outcomes, even when they have a high degree of certitude that they are doing the right thing.

Even though physical harm could be a potential threat, it is more likely that threats will materialize in the form of “humiliation, rejection, ridicule, unemployment, and loss of social standing” (Lachman, 2007, p. 131). A few examples of having moral courage are (1) confronting or reporting a peer who is stealing and using drugs at work, (2) confronting a physician who ordered questionable treatments that are not within the reasonable standard of care, (3) confronting an administrator regarding unsafe practices or staffing patterns, (4) standing against peers who are planning an emotionally hurtful action toward another peer, and (5) reporting another nurse for exploitation of a patient or family member, such as when a nurse posts a picture or story of a patient on a social networking site.

Lachman (2007) offered two strategies to help nurses to exhibit moral courage in threatening situations. Nurses would probably regret any careless and hasty reactions, or even nonreaction or silence, on their part, so they must first try to soothe inner feelings that could trigger these behaviors. Self-talk, relaxation techniques, and moral reasoning to process information, while pushing out negative thoughts,

are ways for nurses to keep calm in the face of a confrontation involving moral courage. Second, nurses must assess the whole scenario while identifying the risks and benefits involved in standing alone.

Concern

Advocacy

A general definition of **advocacy** is pleading in favor of or supporting a case, person, group, or cause, but many variations on the definition of advocacy exist. Related to professional nursing ethics, Bu and Jezewski (2006) found in their concept analysis that **patient advocacy** is defined as having three central features:

- Safeguarding patients' autonomy
- Acting on behalf of patients
- Championing social justice in the provision of health care (p. 104)

Patient advocacy, an essential element of ethical nursing practice, requires that nurses embrace the promotion of well-being and uphold the rights and interests of their patients (Vaartio, Leino-Kilpi, Salanterä, & Suominen, 2006). The ANA (2001) did not define the terms advocacy or patient advocacy in the *Code of Ethics for Nurses with Interpretive Statements*, although advocating for the patient is implied in some places in the code and is also explicit in others, such as in the interpretive statements: “Nurses are leaders and vigilant advocates for the delivery of dignified and humane care” (p. 8) and in Provision 3 of the code: “The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient” (p. 12).

Nurses are in ideal positions for a patient advocacy role. Nurses can clarify and discuss patient rights, health goals, treatment issues, and potential outcomes with patients, but barriers to advocacy often become a nursing reality. These barriers are shadows that remain as unresolved issues. Refer to Box 3.6.

Hamric (2000) offered excellent ways for nurses to boost their patient advocacy skills: (1) nursing educators need to convert the basic ethics education to real-life action; (2) practicing nurses need to continue their education on the ethical imperatives of advocacy; and (3) institutions need to review their incentives, if any, to promote patient advocacy. Butts (2011) created an acronym labeled **PRISMS** as a reminder of strategies to promote patient advocacy (see Box 3.7).

Power

Power, by definition, means that a person or group has influence in an effective way over others—power results in action. Nurses with power have the ability to influence persons, groups, or communities. Nurses ingrained with the ideals of **socialized power** seek goals to benefit others with intent to avoid harm or negative effects—an indication of the principles of beneficence, nonmaleficence, and justice at work. Goals of social benefit to others are usually accomplished through the efforts of members of large service organizations, and individual volunteer work by

BOX 3.6 ETHICAL FORMATIONS: BARRIERS TO NURSING ADVOCACY

Barriers to nursing advocacy were identified by Hanks (2007) based on findings from existing literature.

- Conflicts of interest between the nurse's moral obligation to the patient and nurse's sense of duty to the institution
- Institutional constraints
- A lack of education and time
- Threats of punishment
- A gender-specific, historical, critical social barrier related to nurses' expectations of a subservient duty to medical doctors

Source: Adapted from Hanks, R. G. (2007). Barriers to nursing advocacy: A concept analysis. *Nursing Forum*, 42(4), 171–177.

BOX 3.7 ETHICAL FORMATIONS: PRISMS—AN ACRONYM FOR KEY ACTION VERBS FOR STRATEGIES TO PROMOTE PATIENT ADVOCACY

- P** Persuade
- R** Respect
- I** Intercede
- S** Safeguard
- M** Monitor
- S** Support

Source: Butts, J. B. (2011). PRISMS—An Acronym for key action verbs for strategies to promote patient advocacy. Personal Collection. Ellisville, MS, copyright 2011.

nurses and others at service organizations contributes to the efforts and shared goals of the larger organization and also can contribute to efforts of smaller goals for individuals, small groups, and small areas of the community. Nurses continue to take advantage of their empowerment as a profession in order to control the content of their practice, the context of their practice, and their competence in practice.

Hakesley-Brown and Malone (2007) found in their research that nurses and patients are a powerful entity evolving over time because of paradigm shifts in clinical, political, and organizational power. Nurses have facilitated patients' emancipation from a paternalistic form of care to today's autonomous decision makers seeking quality care. With nurses being directly involved in quality of care, they are in a prime position to use power to benefit patients and the professional practice of nursing.

Ponte et al. (2007) interviewed nursing leaders from six organizations to understand, from the leaders' perspectives on the concept of power, ways that nurses can acquire power and ways that these leaders demonstrate power in their practice and work. Refer to more detail on sources of leadership power in Chapter 12. According

to the leaders in the study, power lies within *each nurse* who engages in patient care and in other roles, such as in organizations, with colleagues, and within the nursing profession as a whole. As nurses develop knowledge and expertise in practice from multiple domains, they integrate and use their power in a “collaborative, interdisciplinary effort focused solely on the patients and families that the nurse and care team serve and with whom they partner” (Ponte et al., 2007, Characteristics of Nursing Power section, para. 1). Ponte et al. found eight properties of a powerful professional practice, which could serve as a basis for current and future power in nursing. Refer to Boxes 3.8 and 3.9.

Culturally Sensitive Care

Culture refers to “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups” (Lipson & Dibble, 2005, p. xi). Giving culturally sensitive care is a core element in closing the gap on health disparities. Spector (2004) explained that providing **culturally sensitive care** means that nurses must first have a basic knowledge of culturally diverse customs and then demonstrate constructive attitudes based on that knowledge. A culturally competent nurse or healthcare provider

BOX 3.8 ETHICAL FORMATIONS: PONTE ET AL.'S PROPERTIES OF A POWERFUL PROFESSIONAL NURSING PRACTICE

Nurses who have developed a powerful nursing practice:

- Acknowledge their unique role in the provision of patient- and family-centered care.
- Commit to continuous learning through education, skill development, and evidence-based practice.
- Demonstrate professional comportment [manner in which one conducts oneself] and recognize the critical nature of presence.
- Value collaboration and partner effectively with colleagues in nursing and other disciplines.
- Actively position themselves to influence decisions and resource allocation.
- Strive to develop an impeccable character: to be inspirational, compassionate, and have a credible, sought-after perspective (the antithesis of power as a coercive strategy).
- Recognize that the role of a nurse leader is to pave the way for nurses' voices to be heard and to help novice nurses develop into powerful professionals.
- Evaluate the power of nursing and the nursing department in organizations they enter by assessing the organization's mission and values and its commitment to enhancing the power of diverse perspectives.

Source: Quoted from Ponte, P. R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrell, R., . . . Washington, D. (2007). The power of professional nursing practice—An essential element of patient and family centered care. *The Online Journal of Issues in Nursing*, 12(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/tpc32_316092.aspx

BOX 3.9 ETHICAL FORMATIONS: TWO LEVELS OF POWER

There are a variety of ways that power can be abusive, coercive, or not used at all. Nurses who do not use their power for the good of a situation are ineffective. There are two examples of power presented here, one on a smaller scale and one on a larger scale.

Power on a Smaller Scale: Ms. Gomez's diagnosis is an inoperable and incurable cancer of the liver. She is unaware of her diagnosis but realizes that she is experiencing abdominal pain that she described as 8 on a 10-point scale. Everyone in the oncology unit is involved in her care and aware of her diagnosis, except for her. The nurses had been observing Ms. Gomez's continued edginess and irritability as they interacted with her. Ms. Gomez senses something is terribly wrong and begins to panic when physicians gather in her room for clinical rounds and talk medical jargon about her "case" in front of her. Ms. Gomez experienced an acute anxiety reaction. Her outcome could have been better had her nurse beforehand discussed the situation with the physicians and tried convincing them to discuss her case somewhere else and/or asked them politely to tell her the truth about her diagnosis and prognosis. Had the nurse exerted a noncoercive power over this situation, the outcome potentially could have been averted. What specific actions could this nurse have taken on a small-scale or unit level in terms of unit policies regarding clinical rounds or disclosure to patients?

Power on a Larger Scale: Nurse Mary is a nurse at a hospice located in a coastal region and has six patients in her care. The national weather center forecasted several potential life-threatening hurricanes for her region during the next two weeks. Most of her patients are financially challenged. Mary has choices to make: (1) she could do nothing and let nature take its course; (2) she could educate her patients and families on ways to prepare for disaster; or (3) she could educate her patients and families on disaster preparedness as well as use her power to help poor, homebound patients—not just her patients—in the community to prepare for disaster. One way for Mary to exercise her power immediately on a large, community-wide scale is to have a fundraiser and supply drive, then work with agencies such as the American Red Cross to recruit community or nurse volunteers for distributing the supplies, handing out disaster preparedness information, and verbally educating the families. What are other strategies that Mary could implement?

develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided. Cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear. (Purnell, 2002, p. 193)

Purnell (2011) explained that the process of nurses getting to know themselves and their values, beliefs, and moral compass is fundamental to providing culturally competent care. Without some degree of cultural knowledge, nurses cannot possibly provide ethical care; one example is that relationships with others cannot develop into a trusting, respectful exchange.

Lipson and Dibble's (2005) trademark name, ASK, serves as an acronym that nurses can use when approaching patients of various cultures; it refers to awareness, sensitivity, and knowledge. There are many cultural views in the United

States, and these are based on each culture's belief system on health, illness, pain, suffering, birth, parenting, death, dying, health care, communication, and truth, among others. Lipson and Dibble (2005) emphasized that nurses need to conduct a quick assessment on cultural diversity needs. The following basic cultural assessment questions are based on ASK:

1. What is the patient's ethnic affiliation?
2. Who are the patient's major support persons and where do they live?
3. With whom should we speak about the patient's health or illness?
4. What are the patient's primary and secondary languages, and speaking and reading abilities?
5. What is the patient's economic situation? Is income adequate to meet the patient's and family's need? (Lipson & Dibble, 2005, p. xiii)

Nurses' authentic attention to cultural diversity and the diversity within each culture promotes ethically competent care, which is essential in everyday nursing practice. Nurses must be open-minded to increasing their knowledge and awareness to the needs of culturally diverse patients. The *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) contains explicit guidelines for giving care to individuals regardless of social or economic status, personal attributes, or nature of health problems. Nursing care based on the code includes giving care with cultural sensitivity.

Refer to Boxes 3.10 and 3.11 to test your moral grounding. In this section on qualities of ethical nurses, you have read about selected qualities that make up ethical nurses—moral integrity, honesty, truth-telling, advocacy, power, and culturally sensitive care.

Nursing Professional Relationships

Nurse–Physician Relationships

Women endured many centuries of oppression from male-dominated hierarchies, such as religious institutions. Women healers, accused of being witches, were burned at the stake from the 1300s to the 1600s (Ehrenreich & English, 1973), and other events also gave rise to oppression of women during that time. By the early 20th century, Florence Nightingale's work from the 1800s had achieved some respect for the role of nurses, but nurses and other mostly female occupations "were presented as simple extensions of women's 'natural' domestic role" (Ehrenreich & English, 1973, p. 38). Nurses, to varying degrees, have been working since that time to overcome this perception.

Stein (1967), a physician, characterized a type of relationship between physicians and nurses that he called the **doctor–nurse game**. The game is based on a hierarchical relationship with doctors being in the position of the superior. The hallmark of the game is that open disagreement between the disciplines is to be avoided, and

BOX 3.10 ETHICAL FORMATIONS: TEST YOUR MORAL GROUNDING!

Thus far, you have learned about the qualities that define ethical nursing. The codes of ethics and the qualities of ethical nurses assist nurses in developing moral grounding for professional practice, education, research, and leadership.

Test your personal moral grounding! List the ethical qualities of a nurse on a piece of paper and write down how they might relate to your ethical nursing practice. Briefly summarize an ethical situation or conflict that could arise with each ethical quality and a corresponding resolution.

Moral integrity

Honesty

Truthfulness

Moral courage

Advocacy

Power

Culturally sensitive care

avoidance of conflict is achieved when an experienced nurse, who is able to provide helpful suggestions to a doctor regarding patient care, cautiously offers the suggestions in such a way so that the physician does not directly perceive that consultative advice is coming from a nurse. In the past, student nurses were educated about the rules of the game while attending nursing school. Over the years, others have given credence to the historical accuracy of Stein's characterization of doctor–nurse relationships (Fry & Johnstone, 2002; Jameton, 1984; Kelly, 2000).

Stein, Watts, and Howell (1990) revisited the doctor–nurse game concept 23 years after Stein first coined the phrase. They proposed that nurses unilaterally had decided to stop playing the game; some of the reasons for this change and ways the change was accomplished have involved nurses' increased use of dialogue rather than gamesmanship, the profession's goal of equal partnership status with other healthcare professionals, the alignment of nurses with the civil rights and women's movements, the increased percentage of nurses who are receiving higher education, and collaboration between nurses and physicians on projects. In the process of the dismantling of the game, many nurses took a less than communitarian stance with physicians.

There are nurses who believe that an adversarial fight needs to continue in order to establish nursing as an autonomous profession. Nurses' reports and opinions of strained relationships between nurses and physicians have steadily appeared in the literature across many countries of the world despite efforts by some nurses to have friendlier relationships with physicians. Reported reasons for the strained relationships include: (1) the hierarchical way that ethical care decisions are made, both institutional system decisions and physician decisions; (2) competency and quality of care conflicts; and (3) the lack of communication.

BOX 3.11 ETHICAL FORMATIONS: TEST YOUR MORAL GROUNDING! SHOULD I BUY THIS PAPER?

Megan, a nursing student, found a site on the Internet advertising a company that, for a fee, would customize a nursing school paper on any topic. She needed a paper in APA format on the concept of compassion in nursing practice and realized that she was overloaded with assignments from school, so she asked herself, "Should I buy this paper?" Without further thought, however, she completed the form and ordered the paper. The company sent the paper to her within 3 days. Megan then submitted the paper electronically to the professor as her own work.

Who is the rightful owner of the paper?

Is buying the paper unethical, illegal, or both? Please explain your rationale.

Is this action cheating, plagiarism, or both, by common university or college standards of academic honesty? Please explain your rationale.

What are some ethical implications that Megan needed to consider before buying the paper?

What was an alternative action for Megan, based on Kant's deontology framework or a virtue ethics approach?

What is a creative strategy that Megan's professor could use instead of the paper assignment to reduce the chance of students buying a paper on the Internet?

What are some examples of other similar Internet incidents considered illegal or unethical?

(The story continues.)

The professor required that electronic versions of the paper be submitted, and Megan did not realize that the professor opened each document to review the name appearing in the properties of the document. The property name on Megan's document was National Nursing Papers. Megan was shocked when the professor questioned her about the name in the properties. She did not realize that a property name even existed. She could not give an adequate explanation for the existing name and finally admitted to buying the paper. She failed the course. Megan was not dismissed from the program for this one academic honesty violation, but the dean and professor gave her a one-time warning notice that if she cheated or plagiarized in any form in the future, she would be dismissed from the school of nursing and the university as instructed in the university's handbook. Megan signed the warning notice. She had no other choice if she wanted to remain in the nursing program.

Do you believe, based on your analysis of the deontology framework, that Megan deserved another opportunity to remain in the nursing program? Please explain your rationale.

One example of research of an organizational culture is a qualitative focus group study by Malloy et al. (2009). Forty-two nurses from a variety of settings in four nations (Canada, Ireland, Australia, and Korea) participated to identify ethical dilemmas and decisions in the everyday care of elders with dementia, as well as to identify how end-of-life decisions are made. The researchers extracted four themes in conjunction with the unexpected finding that nurses from all countries consistently voiced strained and powerless hierarchical relationships with some physicians. The first theme arose as a result of two different philosophies: Care (nurses)

versus treatment (physicians) was a source of tension between nurses and physicians on end-of-life decisions. The second theme was a constrained obligation in terms of the nurse–physician hierarchy, established protocol, and the way that decisions were made. Third, nurses perceived that physicians, patients, families, and the system silenced the nurse’s voice; they also believed themselves to be unequal participants in the care of patients, largely because of the system. The fourth theme was a lack of respect for the profession of nursing from other professionals.

Pullon’s (2008) qualitative study of 18 nurses and physicians in primary care settings from New Zealand is an example of research of the features that build an interprofessional nurse–physician relationship. Pullon identified certain extrinsic and intrinsic factors of this relationship, but focused the article only on the intrinsic nature of individual interprofessional relationships. A key feature of interprofessional relationships, demonstrated professional competence, served as the foundation for respect for each other and, in turn, formed trust calculated over time with reliable and consistent behavior.

Pullon found that nurses and physicians identified their professional groups as distinct but complementary to each other. Nurses described the formation and maintenance of quality professional relationships with patients and others as the heart of their professional work and described teamwork as one means for achieving those relationships. Physicians depicted the physician–patient relationship as the crux of their practice, but only in the context of consultation. Nurses and physicians both unveiled several shared values and attitudes, such as the provision of continuity of care; the ability to cope with unpredictable and demanding care; the importance of working together and building a relationship; and the significance of professional competence, mutual respect for each other, and trust in an ongoing relationship, but with the realization that trust could be broken quickly in the early stages of a trustworthy relationship.

Other studies have reflected findings similar to these highlighted studies. Nurses’ perceptions of inequality with physicians reveal that the solutions are complex and currently do not exist universally. Churchman and Doherty (2010) found that certain factors contribute to the challenge of finding answers: nurses are discouraged from confronting physicians in everyday practice, fear of conflict and aggression by physicians, and fear of having their views disregarded. The institutional hierarchy continues to be a source for unequal rewards and power between nurses and physicians.

Nurse–Nurse Relationships

In the provisions of the code, the ANA (2001) characterized various ways that nurses demonstrate their primary responsibility to their patients (families and communities). Some key indicators found in the code that reflect this responsibility include having compassion for patients, showing respect to patients and to each other, collaborating with other healthcare professionals, protecting the rights and safety of patients, advocating for the patient and family, and caring for and preserving the

integrity of self and others. Patient and family relationships are important, but good relationships with other nurses and with other healthcare professionals are necessary for the successful follow-through of that responsibility to patients.

Unfortunately, nurses often treat other nurses in hurtful ways through what some people have called lateral or horizontal violence (Kelly, 2000; McKenna, Smith, Poole, & Coverdale, 2003; Thomas, 2009). **Horizontal violence** involves interpersonal conflict, harassment, intimidation, harsh criticism, sabotage, and abuse among nurses, and may occur because nurses feel oppressed by other dominant groups, such as physicians or institutional administrators. Kelly (2000) reported that some nurses have characterized the violence perpetrated by nurses against other nurses who excel and succeed as the **tall poppy syndrome**. This perpetration creates an ostracizing nursing culture that discourages success.

Thomas and her research team (2009) studied the causes and consequences of nurses' stress and anger. In their interviews, nurses voiced horizontal and vertical violence as common sources of stress. Thomas (2009) stated, "One of the most disturbing aspects of our research data on nurses' anger is the vehemence of their anger at each other" (p. 98). Thomas (2009) identified common characteristics of horizontal violence as:

- Subtle nonverbal behaviors, such as rolling eyes, raising eyebrows, or giving a cold shoulder
- Sarcasm, snide remarks, rudeness
- Undermining or sabotaging
- Withholding needed information or assistance
- Passive-aggressive (behind the back) actions
- Spreading rumors and destructive gossip
- False accusations, scapegoating, blaming (p. 98)

Horizontal violence in nursing is counterproductive for the profession. Nurses can strengthen a sense of community among nurses by working to heal the disharmony. Nurses need to support other nurses' successes rather than treating colleagues as tall poppies that must be cut down.

There are occasions when unpleasant but nonmalicious action must be taken with regard to nursing colleagues. In addition to advocating for patients' unmet needs, nurses are advocates when they take appropriate action to protect patients from the unethical, illegal, incompetent, or impaired practice of other nurses (ANA, 2001). When nurses are aware of these situations, they need to obtain appropriate guidance from supervisory personnel and institutional policies; then, they need to confront the offending nurses in a constructive, compassionate way. Though action needs to be taken to safeguard patients' care, the manner in which a nurse handles situations involving unethical, incompetent, or impaired colleagues must not be a matter of gossip, condescension, or unproductive derogatory talk.

Thomas (2009) suggested that individual nurses need to self-reflect at the end of the workday by examining their actions and the dialogue they had with others. All nurses, those who follow through with daily self-reflection and those who do not, need to “make a commitment to supportive collegueship” and “refuse to get caught up in workplace negativism” (p. 109).

Nurses on the ‘Net

Many people who use the Internet have already experienced, to some degree, the consequences of unethical or illegal behavior, such as being the target of someone else’s devious actions. There is no doubt that computers influence our personal and professional lives on an everyday basis, and so nurses and nursing students need to understand the potential for unethical and illegal behaviors.

Matters in Moral Spaces

The potential for professional boundary crossings exist as lines and moral spaces become blurred. **Moral space** is defined as “what we live in . . . any space formed from the relationships between natural and social objects, agents and events that protect or establish either the conditions for, or the realization of, some vision of the good life, or the good, in life” (Turnbull, 2003, p. 4). Respect for one another’s moral spaces takes a serious commitment by those who use the Internet. Dozens of ethical codes of conduct exist for users of the Internet, but no matter how many codes exist or what population they serve, the codes are of no use if they are not practiced or if people are lacking in moral integrity. Nurses and nursing students must remain devoted to respecting human beings in all interactions and actions, even social networking. Some of the issues that can violate the principle of autonomy are matters of respect for human beings, self-determination, trustworthiness, confidentiality, and privacy.

Social Networking and Cellular Phones

Nurses are increasingly using social networks to befriend others who have common interests or to keep in touch with long-time friends. Facebook, Twitter, YouTube, and cellular phones have become highly important as communication methods for healthcare professionals, as they have for everyone. Two broad views exist on the degree of value and use of social networking, cell phones, and other media.

On the positive side, nurses and physicians have found value in sharing professional information and knowledge with patients or other nurses and physicians. Some nurses and physicians see social networking as unavoidable, but also as a means of providing minute-by-minute information and updates about healthcare trends and treatments. In 2011, the American Nurses Association published a booklet on the principles of social networking for nurses. The ANA highlighted how these social networking principles fit with the ANA’s three foundational documents,

one of which is the *Code of Ethics for Nurses with Interpretive Statements* (2001). The ANA (2011) stated that social networks “provide unparalleled opportunities for rapid knowledge exchange and dissemination among many people” (p. 3).

Physicians also see value in the use of social networks to take care of routine work, such as refilling prescriptions, answering questions, and sharing informational websites. In 2011, the American Medical Association (AMA) issued a policy statement on professionalism in the use of social media. The AMA stated that social media support “personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, [and] provide opportunity to widely disseminate public health messages” (para. 1).

On the negative side, questions of confidentiality and privacy arise when nurses, physicians, and patients share information with each other on social networks or cellular phones. The public nature of any social communication poses ethical and legal problems, and solutions are usually labeled by employers and other leaders as unclear, gray, complicated, and uncertain.

The growing number of employee violations is driving employers to initiate disciplinary courses of action against personnel who engage in inappropriate behaviors on social network sites and cellular phones and to reenforce old policies or enforce new ones. If the codes of ethics and current hospital policies were followed, new policies on social networking and cellular phone use would not be required. Lee Thomas, Federal Secretary of the Australian Nursing Federation, acknowledged her concern by saying, “Social networking is instant and fun (so I’m told) but people are increasingly using these mediums to complain about employers, fellow staff members and among our colleagues [and] even patients” (2011, p. 23).

In two horror stories, nurses were suspected of patient exploitation and violations of confidentiality and privacy. One occurred in 2010 at Tri-City Medical Center in Oceanside, California. Five nurses were fired and a sixth nurse was disciplined for violating confidentiality. According to a spokesperson at the medical center, there was enough substantial information to warrant the firings of the five nurses, as the fired nurses discussed patient cases on Facebook (“Five nurses fired,” 2010).

In an even more repulsive story in Louisiana, Lee Zurik, Investigator for Fox 8 Live WVUE-TV, stated that St. Tammany Parish Hospital emergency room (ER) nurses were reported by Reba Campbell, ER technician, for allegedly exploiting, making fun of, and taking cell phone pictures of unconscious patients on at least two different occasions. The most recent case involved an overweight man who overdosed on pain and anxiety medications. According to Zurik, Campbell stated:

Clancy [one of the three reported nurses] and the other nurse walks in and puts these glasses on the patient and starts to make fun of him. That wasn’t funny enough, so they took charcoal that we dumped down his throat and painted his face like a football player and said, “Welcome to St. Tammany Parish Hospital ER. This is your initiation for trying to kill yourself.” (Zurik, 2011, para. 10)

Then two other nurses pulled out their phones. Campbell stated the nurses were “taking pictures with their two cell phones of this patient, unconscious, painted like a clown with charcoal and glasses on his face” (Zurik, 2011, para. 12). The nurses evidently had taken pictures of unconscious patients before, because the co-workers had been observed sitting at a desk and ranking the best pictures of different patients. One of the nurses even texted the photos on her cellular phone to a physician who named one patient picture as best in a text reply to the nurse. The attorney representing the unconscious charcoaled patient named the hospital and three nurses in the lawsuit. Of the three nurses and the physician, only one nurse has been fired.

Not related to and before those two incidents occurred, Thomas and her research team (2009) had interviewed nurses across the United States to find meaning in their layers of stress and anger over unethical, harmful, and dehumanizing treatment of patients as part of a larger study to uncover reasons for nurses’ stress and anger. One of the themes that she discovered was “I feel morally sick.” Nurses described situations they had observed as repugnant; they felt physically sick, disgusted, and nauseated, and believed they were powerless to do anything about those abhorrent situations. Thomas’s interpretation of the narratives was that the nurses were experiencing moral distress as a result of their stress and anger. Moral distress is defined in a previous section of this chapter.

The nurses’ narratives in Thomas’s study were depictions of their terrible real-life experiences and feelings regarding stories not related necessarily to social networking. Unethical and illegal events have always been described and exposed by concerned healthcare personnel, but the digital age has brought many incidents to new levels of public exploitation. Sadly, social networking potentially could be a means for nurses to express frustrations in relation to their workplace, coworkers, and patients, but no matter what reasons exist for sharing and divulging information, nurses who do so violate their professional boundaries and most likely will have their license suspended or revoked. Information-sharing of any privileged information amounts to illegal, inappropriate, and unethical violations. Many nurses and physicians are seeing these concerns as a valid worry and accordingly are taking action collectively through professional organizations. The American Nurses Association (2011) published six principles of social networking for nurses. Where patients and nurses and all surrounding issues are concerned in health care, the commitments of privacy and confidentiality serve as the foundation for these six principles of social networking.

The Association of Pediatric Hematology/Oncology Nurses (APHON) recently issued a position statement on ethical guidelines for social networking (“Association of Pediatric Hematology/Oncology Nurses,” 2011). In their social media policy, the AMA (2011) advised that physicians should weigh all of the issues of online presence, such as violations of patient confidentiality, privacy, and relationships. Other professional nursing organizations are already following suit as more issues of confidentiality, privacy, and exploitation have surfaced.

BOX 3.12 ETHICAL FORMATIONS: DOS AND DON'TS OF SOCIAL NETWORKING**Do**

- Know your professional and legal responsibilities to maintain privacy and confidentiality.
- Know and follow your employer's policies on social networking.
- Educate yourself about privacy settings on the sites you use.
- Keep in mind that colleagues, as well as current and future employers, could access your posts, photos, and other activity.
- Remember, your employer has the right to access your online activity on work computers.

Don't

- Disclose any information about patients in your care.
- Upload photos or video of you, patients, or coworkers in a clinical setting.
- Make disparaging comments about patients, your employer, or coworkers.
- Discuss or post stories of clinical events, even if they are shocking or would be of interest to friends.

Source: Quoted from College and Association of Registered Nurses in Alberta. (2010). Dos and don'ts of social networking . . . avoid a social networking nightmare. *Alberta RN*, 66(6), 22–23.

Employers and professional organizations worldwide are taking measures to prevent ethical and legal violations in patient care. The College and Association of Registered Nurses of Alberta (CARNA, 2010) offered some “Dos and Don’ts” of social networking. These guidelines serve as an excellent reminder to nurses everywhere to observe their code of ethics. Refer to Box 3.12 for these guidelines.

Nurses and physicians serve as role models, whether or not they want this role. The newcomers to the healthcare professions emulate the conduct of the role models, both the positive and negative behaviors. It is imperative that existing nurses influence new nurses and other personnel in a positive manner. In most of the codes of ethics for nurses, including the ANA code, there is explicit discussion about nurses maintaining respect, confidentiality, and privacy; those same concepts are applicable to social networking and cellular phone use.

KEY POINTS

Nursing ethics is defined as the examination of all kinds of ethical and bioethical issues from the perspectives of nursing theory and practice. To practice nursing ethically, nurses must be sensitive enough to recognize when they are facing seemingly obscure ethical issues in their everyday work. Within the 2001 ANA code are nine moral provisions that are nonnegotiable with regard to nurses' work. Detailed guidelines are found in the accompanying interpretive statements of each provision.

KEY POINTS (continued)

A clear patient focus in the code obliges nurses to remain attentive and loyal to each patient in their care.

A theme common to the ANA (2001) and ICN (2006) codes is a focus on the importance of compassionate patient care aimed at alleviating suffering.

Boundaries facilitate a safe space in a relationship, because they give each person in the relationship a sense of legitimate control, whether the relationships are between the nurse and patient, the nurse and physician, the nurse and administrator, or nurse and nurse.

Nurses with moral integrity act consistently with their personal and professional values.

Nurses' moral distress occurs when institutional constraints prevent them from acting in a way consistent with their personal and professional values that make up their moral integrity.

Nurses' work involves hard choices that sometimes result in avoidance of patients, emotional and physical suffering, painful ambiguity, contradiction, frustration, anger, and guilt.

Research reveals a link between moral distress and the concepts of incompetent or poor care, unsafe or inadequate staffing, overwork, cost constraints, ineffective policy, futile care, unsuccessful advocacy, the current definition of brain death, objectification of patients, and unrealistic hope. Truth-telling means that nurses should not intentionally deceive or mislead patients.

No matter how disappointing the news will be to patients and families, nurses must evaluate the situation carefully with wisdom and contemplation before making any decision on the degree of information disclosure. When nurses have the moral courage to do what they believe is the right thing in a particular situation, they make a personal sacrifice of possibly standing alone but will feel a sense of peace in their decision.

Patient advocacy, an essential element of ethical nursing practice, requires that nurses embrace the ideals of the promotion of well-being and uphold the rights and interests of their patients.

Nurses ingrained with the ideals of socialized power seek goals to benefit others with the intent to avoid harm or negative effects.

Nurses' genuine attention to cultural diversity and the diversity within each culture promotes ethically competent care, which is essential in everyday nursing practice.

For a successful nurse–physician relationship, three essential features need to be present: competence, respect, and trust.

Nurses often treat other nurses in hurtful ways. Many refer to this treatment as horizontal violence.

KEY POINTS (continued)

Social networking invokes questions of confidentiality and privacy when nurses, physicians, and patients share information with each other. The public nature of social communication poses ethical and legal problems, and solutions are usually unclear.

The growing number of employee violations arising in social network sites worldwide is driving employers to initiate disciplinary courses of action against their personnel and to enforce new policies to prevent inappropriate behaviors.

CASE STUDY: JILL BECOMES DISHEARTENED



Jill is a 28-year-old, attractive, intelligent, and technically competent RN who has worked for 5 years in a medical-surgical unit of a small hospital. She has been well liked by her professional colleagues, and she habitually makes concerted attempts to deliver compassionate care to her patients. Recently, she left her job and began working in the busy surgical intensive care unit (ICU) at a local county hospital. Jill changed her job because she wanted to gain more-varied nursing experience. She was very excited and enthusiastic about her new job, but shortly after Jill began working in the ICU, she began to question her career decision. The more experienced nurses in the ICU are what Jill describes as “abrupt” and “exasperating” when she asks for help in learning ICU patient care and procedures. Jill states that the ICU nurses seem to be “testing my resolve to stick it out” and seem to want her to fail at learning how to work in the ICU. Many of the surgeons who regularly have patients in the ICU are described as being demanding and impatient with the ICU nursing staff. In addition to being intimidated by the ICU nursing staff, Jill says that she also is very intimidated by the physicians and was chastised by one of them for asking what he called “a stupid question.” There

is an “air of unhappiness” among all of the nurses throughout the hospital. Jill says working at this hospital is like no other situation that she has been involved with since becoming a nurse.

1. What do you believe are the underlying causes of the ICU nurses' treatment of Jill? Do you believe that it is likely that Jill's treatment has anything to do with her personal characteristics?
2. What could Jill do to try to improve her situation?
3. What are the possible implications in Jill's delivery of care that could arise because of the treatment that she is experiencing?
4. Do you believe that the “air of unhappiness” among all of the nursing staff at the hospital might be directly or indirectly affecting the treatment that Jill is receiving? Might it be affecting patient care hospital-wide? Give your rationale.
5. If Jill wants to make positive changes at the hospital, what can she do?
6. What qualities of an ethical nurse will Jill demonstrate when developing the strategies and proposing her plan to hospital administrators for making positive changes? Give your rationale.

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