

CHAPTER OUTLINE

- ▶ Introduction
- ▶ The Relationship Between Respect and an Ethical and Cultural Context for Care in the Community
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 - Code of Ethics
 - Selected Ethical Principles
 - Ethical Issues in the Community
 - Community Engagement and Social Action in Health Care
- Ethics, Values, and Moral Reasoning Related to Community Health Nursing
- Ethical Decisions of the Community Health Nurse
- ▶ A Cultural Context for Care in the Community
 - The Influence of Health Beliefs and Culture on Health Care
 - Cultural Variations in Social Interaction
 - Cultural Sensitivity of the Community Health Nurse
- ▶ Summary

OBJECTIVES



1. Explain how the concept of respect relates to both an ethical and cultural context for providing care in the community.
2. Identify the ethical principles that guide community health nursing care delivery, education, and research.
3. Discuss how personal values influence the types of community-based services that are made available to the public.
4. Prioritize the list of major community health problems that need resolution in the learner's local community.

KEY TERMS



Advance medical directives

Autonomy

Beneficence

Code of ethics

Confidentiality

Curandero

Distributive justice

"Do not resuscitate" (DNR) order

Egalitarian justice

Environmental press

Ethical pluralism

Ethics

Health Insurance Portability and Accountability Act (HIPAA)

Informed consent

Ladder of participation

Scope of practice

Third-party payment

Utilitarian justice



CHAPTER 2

Respect for an Ethical and Cultural Context for Care in the Community

Marilyn Klainberg

RESPECT

If we lose love and self-respect for each other, this is how we finally die.

—Maya Angelou (1928–)



Introduction

This chapter examines two interrelated concepts—ethics and cultural beliefs. These concepts are related through their fundamental grounding in the client's personal beliefs and life experience. The first part of the chapter defines ethics and discusses ethical concerns that are central to the practice of community health nursing. These issues include advance directives, quality of life, the cost and rationing of health care, the increasing use of technology, and the way in which the community health nurse (CHN) works in an ethical environment.

The second part of the chapter examines culture and the influence of culture on providing and receiving nursing care in the community. In the United States, clients seeking nursing care in the community come from a variety of cultural backgrounds. For some of these individuals, understanding the importance of culture is the key to developing a therapeutic and lasting nurse–client relationship.

The Relationship Between Respect and an Ethical and Cultural Context for Care in the Community

Demonstrating respect for the health-related choices of clients (as individuals, families, aggregates, and communities) is the responsibility of nurses working in the community. Respect becomes authentic when it encompasses the ethical and cultural context or setting where care is delivered. This chapter examines both the ethical and cultural context for providing care in the community, and considers how the CHN can participate in care with respect for the decision-making process employed by various clients. Ethical and cultural concerns arise when working with all individuals, families, other groups, and communities as a whole. The CHN needs to be aware that respect for the client, in whatever configuration, is central to the success of providing care from a sound ethical and culturally sensitive perspective.

An Ethical Context for Care in the Community

Like other healthcare providers, the CHN faces innumerable moral decisions and ethical dilemmas each day. Working in a community setting may entail working in community-based agencies, public health institutions, clients' homes, or other places where clients reside. The CHN, therefore, operates within a framework of ethical and moral decision making that is often unique. Each community has its own culture, values, and morals that may be distinct and influence the decision-making process. Ethical and moral decisions are based on a standard of behavior developed within a culture or society. Nurses are guided by a professional code of ethics as they develop various nurse–client relationships (American Nurses Association [ANA], 2001; Fowler, 2010).

An ethical approach to the provision of health care is a mandate of nursing. Nurses' code of ethics interprets moral principles upon which nursing actions are measured. These principles include respect for a person's autonomy and the ideas of beneficence, nonmaleficence, veracity, confidentiality, and justice. Since 1953, guidance on ethical action has also been provided on an international level by the International Council of Nurses (ICN). The international code of ethics addresses the need for nurses to respect human rights as they provide care to their clients. The ICN code has been made

available in a variety of languages, and is available on the organization's website (<http://www.icn.ch>).

Ethics Defined

The definition of **ethics** is complex. Although ethics are intensely personal, they also reflect the society in which one lives. Ethics is often referred to as a system of moral principles, or the rules or guidelines of a particular group, culture, or society. It is the branch of philosophy that deals with values and moral principles related to human conduct. Whether one's actions are considered right or wrong or good or bad is often determined by one's culture (Dayer-Berenson, 2011; Skott, 2003).

The impact of a culture on ethical decision making was identified by Kurt Lewin as environmental press. **Environmental press** refers to the pressure brought upon individuals by a culture or society that produces specific behaviors. Environmental pressures may either facilitate or inhibit a person in behaving in certain ways (Lewin, 1936). A person's behavior, according to Lewin's theory, is a function of the relationship between the person and the environment. This theory is illustrated by the following example.

Since the late 1980s, as a result of economics and improved technology, providers of healthcare services in the United States have begun to debate the issue of rationing health care for severely disabled and elderly persons. Until this time, it had been the goal of health care providers to dispense equal care to all. Recently, however, cost factors and issues of quality of life related to health care have raised fundamental questions about the aims and goals of health care. Despite this dialogue concerning cost containment, basic values related to health care presently remain the same. It is, however, a significant matter, and with changes occurring in society and how health care is provided, it is an issue that continues to be deliberated (Ray, 2010).

Code of Ethics

Many professional groups have a code of ethics or principles that acts as a beacon, guiding group members toward the way in which the profession is conducted. A **code of ethics** comprises the rules by which a profession is guided. The American Nurses Association has developed a code of ethics that expresses the duties, values, and ethical responsibilities of the professional nurse. Nurses accept a moral and legal obligation to abide by this code when they accept the role of the nurse in all client-care settings. **Table 2-1** summarizes the key aspects of the ANA code (ANA, 2001; Fowler, 2010).

Selected Ethical Principles

Autonomy

The term **autonomy** means independence or self-determination. Autonomy is the right of individuals and society to decide for themselves how to mandate their own lives. The notion of autonomy implies respect for each person as unique and maintains each person's right to determine his or her own destiny. Autonomy is an important part of American bioethics and means that adults have the right to make their own healthcare decisions. When the community determines how persons should choose, even if the client's choice is considered "bad" by the larger society, the society is imposing its will over the rights of an individual.

Although this imposition may seem to be in conflict with human rights, a society imposes its decisions when it believes that those decisions will ensure the betterment and safety of the larger community or are in the best interest of the individual. Examples include mandated laws related to the use of seatbelts and the deterrence of smoking in

Ethics: A system of moral principles, or the rules or guidelines of a particular group, culture, or society.

Environmental press: The pressure brought upon individuals by a culture or society that produces specific behaviors.

Code of ethics: The rules by which a profession is guided.

Autonomy: Independence or self-determination.

TABLE 2-1
Code of Ethics of the American Nurses Association

| | |
|----|--|
| 1. | The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. |
| 2. | The nurse's primary commitment is to the patient, whether an individual, family, group, or community. |
| 3. | The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. |
| 4. | The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care. |
| 5. | The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth. |
| 6. | The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action. |
| 7. | The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development. |
| 8. | The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs. |
| 9. | The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy. |

Source: © 2001 Code of Ethics for Nurses with Interpretive Statements. By American Nurses Association. Reprinted with permission. All Rights Reserved.

Advance medical directives:
Legal orders that permit clients to choose in advance the type of healthcare treatment they want.

"Do not resuscitate" (DNR) order: A medical order to abstain from cardiopulmonary resuscitation if the client's heart stops beating.

public places. These issues of prevention and safety are controversial: On the one hand, they are aimed at increasing wellness; on the other hand, they create are an ethical dilemma in that they interfere with the autonomy of the individual. Autonomy means that people have the right to make their own healthcare decisions, whether good or bad, without interference from the society in which they live.

The degree of participation and a striving toward autonomy by the individual or the community as a whole often indicate how well the community or an individual has succeeded in self-care or wellness. The degree of autonomy often predicts the degree of success that will be achieved in regard to a health goal. Because the extent to which individuals have control over their own lives affects their well-being, empowering clients to take charge of healthcare decisions is a primary health promotion strategy.

Advance medical directives such as a **"do not resuscitate" (DNR) order** are examples of how clients can have a voice in their care. A DNR is a medical order to abstain from cardiopulmonary resuscitation (CPR) if the client's heart stops beating. Other advance directives permit clients to choose in advance the type of treatment they want if they become too ill to indicate the care they want. Likewise, the right to receive or refuse treatment is a major ethical issue. The growth in the number of clients with long-term care needs or hospice care

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needs at home (either by family members or home health attendants) raises ethical questions of a different nature.

In caring for a client at home, the principle of autonomy related to medical issues remains clear; however, unlike in institutional settings, issues related to client care issues at home are often complex. Outside of the institution, there are other persons whose rights and interests are affected by the client's choices, and these considerations must be included when decisions are made. In these situations, autonomy may give way to accommodation, as part of an effort to include the needs of the family in the decision-making process. For example, if the main caregiver is unable to provide all the care necessary and desired by the client, the community health nurse may need to assist the family to accommodate and meet the needs of all parties concerned.

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Beneficence

Beneficence is a healthcare principle that mandates that the healthcare provider “do good for the client.” Adhering to this principle may become a complicated issue when the healthcare provider also attempts to do that which the client wishes. If there is conflict between what is considered good by the profession and what the client wants, the nurse must abide by the client's wishes as long as it is within the professional scope of practice.

Nurses have the responsibility to inform and teach clients about their healthcare needs but should not attempt to impose their own or society's wishes upon the individual. For many religious groups, as a result of their beliefs and restrictions, this is an important issue. Hospitals in affiliation with such populations are developing outpatient as well as in-hospital settings to meet the needs of specific groups; for example, bloodless clinics have been established to care for Jehovah's Witnesses so that they may receive health care in a setting that is appropriate and supportive of their religious beliefs. Bloodless medical and surgical programs provide options for other individuals who do not wish to have a blood transfusion because of religious beliefs, personal choice, or other medical restrictions such as allergies, fever, or fear of infection.

Beneficence: A healthcare principle that mandates that the healthcare provider “do good for the client.”

Confidentiality: The obligation to uphold a client's privacy, maintain certain information in confidence, and respect the client's autonomy.

Confidentiality

An important component of all healthcare professions, but especially nursing within a community, is **confidentiality**. An obligation to uphold a client's privacy and maintain certain information in confidence has long been part of nurses' code of ethics. Health information that an individual considers private must be kept confidential. The issue of privacy envelops the values of individual autonomy. Privacy also encompasses the right of the individual to be left alone and free from unwanted publicity. Confidentiality is merely the tool for privacy protection (Goodman, 2010; Sheldon, 2009).

In health care, the meaning of confidentiality goes beyond keeping information imparted to the healthcare provider secret—it reaches to the core of the relationship between the client and the community nurse. It is an obligation of the nurse to preserve the confidentiality of the client. The code of ethics for nurses developed by the ANA embodies the concept of a client's right of privacy by stating that the nurse has an obligation to protect the client's privacy and confidentiality. Without such protection, the client may not be completely honest with the nurse, which might inhibit other aspects of the client's care as well as the well-being of the community.

In rare situations, the nurse may need to break this confidentiality, such as in a situation in which the failure to disclose information could cause serious harm to the client, the family, or others; in this case, disclosure may be legally binding upon the healthcare provider in some states. For example, if a mentally ill client threatens the life of another person, or if a client with acquired immunodeficiency syndrome (AIDS) confides that

he or she is knowingly spreading the disease through unprotected sexual activity, the nurse may be required to break confidence with the client. In some states, healthcare providers (usually the physician) have a “duty to warn”; in other states, however, disclosure of information remains prohibited by law.

Justice

The most common perspectives of justice are distributive, egalitarian, and utilitarian. An important notion of **utilitarian justice** is that benefits should be first given to those who need them the most; thus, if there is a choice or a decision related to the provision of care, the best or most efficient choice should be made. An example of utilitarian justice is a situation, such as an accident, in which there are limited resources and one victim can be saved and another cannot; in these circumstances, care would be provided to the victim with the best chance of survival.

The concept of justice in providing care to a community is based on the notion that people are treated fairly (Mayer & Cronin, 2008; Rawls, 1971). The basis of this concept of justice is **egalitarian justice**. The notion of egalitarian justice or equal justice is that each person has equal access to the health services he or she needs. The idea of fair and equal treatment is dependent, however, on issues that may be difficult to determine or may even be immeasurable. Equal access to care may be affected by many factors; for example, where one lives (e.g., an urban versus rural location) may influence the actual delivery or access availability of services to a client or a community, thereby influencing the equity of care. In some situations, justice as fairness requires allocation of resources that does not reflect equality. People in need may need more resources than others, and it would be just to recognize that reality.

Economics certainly has an effect on how health care is provided for a population or an individual client. If communities or nations have limited economic resources, the health care they provide, although equal among their members, may be less than the services provided to residents in other communities or nations. Although nurses should provide care as needed to all clients regardless of financial status, inequities may occur based on financial realities.

In a healthcare system that uses **distributive justice**, healthcare services are distributed in the fairest way possible to all according to need. Although the principle of justice is the promotion of equity, using equity alone to measure justice is not sufficient. The needs of the community or an individual and availability of resources must be established to determine a just distribution of care (Lachman, 2009; Mayer & Cronin, 2008).

Ethical Issues in the Community

The need to explore ethical issues in relation to community health is not new, but has certainly grown in importance in recent years. The healthcare system in the United States is undergoing an enormous transformation caused in part by factors such as the high cost of health care, improved technology, increased awareness by a concerned and informed population, the aging of the population, the high cost of health insurance, and the lack of health insurance for some individuals.

Advance Directives

Rapid advancements made in healthcare technology, in addition to a changing economic climate, have had an enormous influence on the home care system. Formerly limited to hospitals, highly technological care—such as that requiring intravenous therapy or respirators—may now be provided to clients at home. Some clients may be sent home on respirators or with intravenous lines with little or no support system in

Utilitarian justice: A system of justice based on the principle that benefits are first given to those who need them the most.

Egalitarian justice: A system of justice based on the principle that people are treated fairly; also known as equal justice.

Distributive justice: A system of justice based on the principle that benefits are distributed in the fairest way possible to all according to need.

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place other than home care visits by the community health nurse; however, these visits are also limited by insurance coverage. Thus, advance directives, such as DNR orders and the healthcare proxy, which are standard in hospitals, are now available to clients at home. Other advance directives include a living will and a durable power of attorney for health care. As noted earlier, advance directives are documents of empowerment that extend the autonomy of clients beyond the point at which they lose their capacity to choose their own care. Because this has become an issue of concern in the care of clients in the community, nurses must provide information to clients about advance directives that are available for use at home.

The living will and healthcare proxy appoint a surrogate decision maker to act on the client's behalf. DNR orders, by comparison, are related only to resuscitation. At-home DNR orders tell emergency staff or attending personnel not to transfer the client to a hospital for CPR. Signing a healthcare proxy allows clients to appoint someone they trust to make decisions about care in case they lose their ability to make decisions. Clients select someone they know as their healthcare agent; they can give that individual as little or as much authority as desired regarding the client's health care or healthcare treatments.

As an advance medical directive is a legal document, clients need to discuss carefully with their healthcare agent what they would or would not want the agent to do if a decision had to be made. This could include not providing CPR, artificial nutrition, hydration, transplant, and so on. The community health nurse provides information to a community about the availability of the healthcare proxy and other advance directives to clients in the hospital as well as to individual clients at home. An example of a pocket-size healthcare proxy is shown in **FIGURE 2-1**, and a standard advance directive/

| Healthcare Proxy | | |
|--|----------------------|--------------|
| I, _____, of | | |
| Street | City | State |
| | | |
| Daytime Phone | Evening Phone | |
| | | |
| <i>hereby appoint</i> _____, <i>of</i> | | |
| Street | City | State |
| | | |
| Daytime Phone | Evening Phone | |
| | | |
| <i>as my healthcare agent to make all healthcare decisions for me if I become unable to decide for myself, including decisions about artificial nutrition and hydration.</i> | | |
| | | |
| Signature (Proxy Initiator) | Date | |
| <i>This proxy was signed in my presence. The signer is known to me and appears to be of sound mind and to act of his/her own free will.</i> | | |
| | | |
| Witness | Date | |
| | | |
| Witness | Date | |
| | | |

Figure 2-1 Pocket-size healthcare proxy.

(1) I, _____,

(please print your first, middle, and last names)

hereby appoint _____,

(please print your proxy's first, middle, and last names)

of _____,

(please print your proxy's home address and telephone number)

as my healthcare agent to make any and all healthcare decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own healthcare decisions.

(2) Optional instructions: I direct my proxy to make healthcare decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

Unless you state your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on the back for samples of language you could use.

(3) Name of substitute or fill-in proxy if the person I appoint above is unable, unwilling, or unavailable to act as my healthcare agent.

(please print your substitute proxy's first, middle, and last names)

(please print your substitute proxy's home address and telephone number)

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition stated below. This proxy shall expire (specific date or conditions, if desired):

(5) Signature _____ Address _____ Date _____

(6) Statement by witnesses (the person who is appointed agent or alternate agent cannot sign as witness, and must be 18 or older) I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____ Address _____

Witness 2 _____ Address _____

Figure 2-2 Standard advance directive/healthcare proxy.

healthcare proxy is shown in **FIGURE 2-2**. The CHN should find copies of these documents used by their employing institution so that the most up-to-date forms are used.

The Economics of Health Care in the Community

The influence of the insurance industry on the healthcare system exemplifies the impact of business on healthcare services, including home health care. The emergence of managed care reflected the sway of these changes, and is yet another indicator of a need for change in the way health care is financed. At this moment, the need for changes in the healthcare system or healthcare reform is a hot political issue.

Economics certainly has an effect on how health care is provided for a population or an individual client. If communities or nations have limited economic resources, the health care they provide, although distributed equally among their members, may be less than the services provided to other communities or nations. Ethicists are concerned with many issues related to the right to equal care and the equivalent provision of health care.

Prior to the availability of health insurance, patients paid physicians directly for health care—an example of a direct fee-for-service financing model. The introduction of a third-party payment system (health insurance) significantly altered how a client receives healthcare services and, therefore, influenced and changed every aspect of health care. **Third-party payment** refers to a system in which the healthcare provider is paid by insurance companies for services rendered; that is, the fees for care are paid by the insurance provider rather than solely by the patient. Until recently, this meant the client would seek out the services of a physician, and the insurer would pay a percentage of the cost of those services. The insurance company had guidelines as to what would or would not be covered by its policy and the amount it would pay for a specific service.

Third-party payment: A system in which a healthcare provider is paid by insurance companies for services rendered; that is, the fees for care are paid by the insurance provider rather than solely by the patient.



The client and the physician had the most control over the selection of service. The physician could then order almost unlimited laboratory work, and the client could select any physician. This approach also meant patients could obtain direct access to specialists without prior consultation with a family doctor. Over time, this flexibility grew to be very costly in terms of dollars and provided fragmented patient care and, at times, expensive or unnecessary care for the client. The concept of managed care was introduced in response to this trend. Managed care attempted to control cost and prevent fragmented care by having the caregiver act as the gatekeeper for services provided to the client.

In the United States, the high cost of health care is largely due to a system of care that has traditionally focused on crisis intervention as opposed to prevention. In addition, an aging population has created demands and put pressure on the healthcare system to change from the existing insurance-based system and to provide a new healthcare delivery system, with an emphasis on prevention, health promotion, and wellness. Adding to this challenge are increasing costs for traditional hospital care, which have led to shorter hospital stays and an increased need for care following hospitalization, given that patients are sicker while being treated on an inpatient basis. As the system continues to evolve and change, health care—particularly care of the client in the community and at home—has been and continues to be significantly influenced by these changes.

To deal with the high cost of care, some countries have decided to withhold high-tech care from elderly clients because the cost to society is too great. Ceilings on surgical procedures exist in many countries simply because the economic burden upon the community is too great; thus, clients older than a certain age may not be entitled to certain medical procedures. This approach raises the ethical dilemma of for whom and at what age it is reasonable to receive healthcare services. Financial issues are presently a concern in the United States, as the guidelines for health care are based on cost factors that are changing how health care is provided. The alternative to limited health care based on economics is a society that provides care in spite of its cost or because there are no limits.

Today, a U.S. physician and institution can collect insurance compensation regardless of whether there is a logical basis for an intervention. For example, if a 90-year-old woman with end-stage Alzheimer's disease is scheduled for a hysterectomy for fibroids, the surgeon is paid by the insurer despite the questionable logic of performing such a procedure. Clients can be exploited in this way when the benefit of treatment is not clear. Unfortunately, when resources are used ineffectively, other people who need care may not receive the care they need. Problems with allocating limited resources becomes a dilemma for the community health nurse manager, who often must decide which community or person receives the limited healthcare services that are available.

Technology and the Cost of Care

Changes in demographics and shifts in populations affect a healthcare system. In the United States, for example, the increase in the country's aging population is altering the delivery of care. Limited resources to meet the needs of the elderly in hospitals are creating a need to expand services at home, which in turn is increasing the burden on the community healthcare provider. Utilizing limited funds to provide programs to promote wellness and healthcare services has placed an economic strain on the healthcare system.

Improved technology, the high cost of health care, and deep financial cuts have further diminished the pool of healthcare services for many, particularly those with no or limited health insurance. Allocation of limited services to the community and individuals at home places a strain on the community health nurse. Ethical dilemmas concerning community health issues have grown as the general needs of society have changed and transformed how healthcare needs are met.

Like falling dominoes in a row, the effects on one component of health care affect another healthcare element; for example, shorter hospital stays make increased home care

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necessary, which has had a major effect on home healthcare services. People are discharged from hospitals earlier than ever before following childbirth, surgery, and other medical treatments. Such early discharge often limits the time available for pre-discharge healthcare education and may restrict the development of a thorough discharge assessment and plan for many clients at home.

Economics certainly has an effect on how health care is provided, whether for a population or for an individual client. When communities or nations have limited economic resources, the amount of health care they provide, although equal among their members, may fall short of the amount of services provided to other communities or nations. Although ideally nurses will provide care as needed to all clients regardless of financial status, some inequities may arise based on financial realities.

Technological advances in health care and innovative research in recent years have increased longevity, but economic constraints make it difficult to provide safe environments for many aging or debilitated clients at home. Care of the client at home, using sophisticated equipment such as a respirator, is often offered with limited support to the family or the client. The burden of care sometimes proves too great for families, and it is the family and the community health nurse who must deal with the resulting dilemmas, often facing closed doors for the financial support from an overburdened insurance structure. Self-help or voluntary help programs are sometimes available to add support.

Community Engagement and Social Action in Health Care

Social concerns of a society may help to create a basis for meeting community needs. Health concerns of a society are often reflected in the development and implementation of health education and prevention programs. The need for a preventive approach, rather than a strictly curative effort, has grown and changed the role of the nurse. Examples of this trend include health promotion and educational programs within a community to offer immunization against the flu, to provide injection drug users with clean needles, and to instruct members about the use of condoms to prevent the spread of sexually transmitted diseases and avoid pregnancy among adolescents. Additionally, healthcare concerns involving substance abuse, spousal abuse, child abuse, and AIDS are situations addressed by the CHN, whether the CHN serves as a community health educator, as a group leader, or in the expanded role of the school nurse.

Volunteer hospice workers who become friendly visitors to the dying and hospice professionals provide care at minimal cost; support groups for caregivers and respite programs are examples of communities negotiating these situations together in a positive manner. Although such services do not replace services lost to clients, they represent positive ways in which a community can begin to address its own healthcare needs. Many self-help groups exist for individuals with serious diseases such as Parkinson's disease, multiple sclerosis, cancer, and many others. These groups may initially be organized by or utilize the expertise of the CHN. Most local libraries have information about finding local self-help and volunteer groups in the community.

For any community program to be successful, there needs to be acceptance of that program by the community and an understanding of the needs fulfilled by the program. It is costly and of questionable benefit to a community to simply provide a healthcare program without the understanding by the community of need for the program. Arnstein, a social planner in the late 1960s, developed a method of measuring community participation called the **ladder of participation**, which measures the participation of

Ladder of participation:

Arnstein's method for measuring the participation of a community in eight steps, ranging from nonparticipation to citizen control.

a community in eight steps, ranging from nonparticipation to citizen control (Shetland Islands Council, 2011). The first step is manipulation and the second step is therapy, both of which are considered areas of nonparticipation by a community. During these first two steps, the CHN can educate the community or client or provide services to the community.

Steps 3, 4, and 5 are considered degrees of tokenism by the community. Step 3 is the informing step, step 4 is consultation, and step 5 is identified as placation. During these steps, clients may heed information and attempt to have a voice, but they are not considered in the community healthcare planning. The CHN must include clients during the planning stages of programs and provide for client input during this phase.

Steps 6, 7, and 8 of the ladder are considered various stages of empowerment. Step 6 is partnership, step 7 is delegation of power, and step 8 is citizen control. During these stages, citizens engage in a partnership with healthcare providers, but it is not until step 8 that communities fully participate in an equal partnership with health professionals, with clients taking charge of their own health and community members making a commitment to carry out a healthcare plan.

The ladder of participation illustrates how a community embraces an issue (e.g., a healthcare issue), takes charge of its own health decisions, and improves its own health promotion activities. The CHN has an important role in providing information by educating the community. How the members of a community decide to implement or participate in the community's health is influenced by a variety of issues (ANA, 2010).

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Ethics, Values, and Moral Reasoning Related to Community Health Nursing

Today, the CHN, as part of the healthcare team, must often deal with situations unlike those encountered in the past. Even as technology has developed and enhanced our lives, it has also brought many moral dilemmas. Community health nurses must be concerned with the growing responsibility to confront these ethical and moral decisions in today's complex society.

Moral Reasoning and Health Care

Moral attitudes and behaviors are developed through a combination of many factors. The environment in which one is raised, the family, the culture, and the society all play important roles in the development of one's morals. Kohlberg's work suggests that moral development goes through various stages of development that are characterized by different ways of understanding right or wrong (Crain, 1985). According to Kohlberg, individuals pass through these stages in an orderly fashion, moving from a lower stage of moral development to a higher stage. Moreover, all individuals in all cultures go through these stages, albeit to varying degrees. Kohlberg also claims that each successive stage is at a morally and cognitively higher level than the previous stage. Furthermore, his work indicates that at each higher stage of moral development, individuals are able to deal with moral and ethical problems of greater complexity. The choices one makes, then, depend on one's moral and ethical development.

Gilligan's work on moral development elicits differences in the moral understandings between men and women (Gilligan, 1982). Gilligan suggests that men and women interpret moral problems from distinct orientations; that is, men's moral development is based on the ethic of rights and justice, whereas women's moral development is based on the ethic of care and responsibility.

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Both Kohlberg's and Gilligan's theories are useful to the CHN in working with aggregate populations or individuals to create a positive and informed environment in which to help the client make health-care decisions.

Moral action should support the needs of society. Health care, until recently, claimed to be grounded in this idea. However, as the health-care system previously functioned in a curative domain, there was little interest in prevention. Thus a question arose about whether this perspective was truly in the collective interest of society. The notion of collective interest may not have changed, but how we provide care to the society has certainly been challenged.

Individual Good Versus Societal Good

Sometimes, the CHN in working with communities must consider the needs of an individual or an aggregate over the needs of the community. The health needs of one member or an aggregate population of a community may vary in terms of time, cultural differences, physical needs, technological levels, and economics from the health needs of the community as a whole. At times, this diversity may indicate a need for an individual approach to meeting some immediate or long-term goals. Accommodating the needs of individuals may place an economic burden on the larger community, which may benefit only a few. Examples might include a community that provides sidewalk cuts to meet the demands of wheelchair users and a community that provides kneeling buses to meet the needs of persons who are otherwise unable to access public transportation. As identified previously, the planning process for such a program must consider how the community will participate in the program.

Legal Issues

Providing health care to the community presents legal issues that concern the community nurse. All healthcare workers are responsible for practicing within a framework of laws. These laws reflect the mandates of local, state, and federal legislation. Community health nurses practice under three types of laws: constitutional law, legislative law, and common law. These legal guidelines shape how community health workers practice, as well as govern the private and community healthcare agencies under which nurses provide service. Therefore, nurses have legal standards, in addition to ethical standards, under which they practice.

The community nurse must know and follow closely the state laws and the Nurse Practice Act, which designates the **scope of practice** under which the nurse operates. The CHN may be a generalist, a clinical nurse specialist, a midwife, an occupational health nurse, a school nurse, or a nurse practitioner. It is important that the nurse operate in the appropriate scope of practice, according to the role designated by each state. To do so, the CHN must know the legal limits of nursing practice within the community being served. Furthermore, scope of practice differentiates between the nurse's role in the care of the client and that of other healthcare professionals.

What may be good for society may sometimes come at the cost of endangering an individual—for example, when human subjects participate in research. Because many CHNs are nurse researchers, they must be cognizant of the risks involved with human subjects in the research process. Ideally, by informing the client of the risks, a collaboration develops between the researcher and the subject. At the core of the research process is the informed consent procedure, which attempts to balance the risks to human subjects against the potential benefits to society (Burns & Grove, 2005).

Community health nurses involved in research, like any other researcher working with human subjects, need to obtain **informed consent** from clients. Research involv-

Scope of practice: The legal limits of nursing practice within the community being served, as defined by state law and the Nurse Practice Act.

Informed consent: A process in which a research subject is educated about the terms, procedures, and potential risks and benefits before agreeing to become involved in research.



ing human subjects should not be carried out unless the importance of the research is in proportion to the risk to the subject (Burns & Grove, 2005). It is a most important moral principle of informed consent that the client understand the terms, procedures, and potential risks and benefits before agreeing to become involved in research.

Quality of Life Versus Quantity of Life

Issues such as equity in allocation of resources to individuals or society, the client's right to choose his or her quality of life, euthanasia for home-bound clients, and decisions on how one should live with an illness or potential illness are examples of ethical dilemmas regarding quality of life versus quantity of life with which community health nurses are concerned. Choices regarding clients' right to the quality of life they desire versus greater longevity are often driven by economics related to the healthcare system. Clients with large economic resources or with celebrity often stand a better chance of being a recipient of improved services. This has recently become a concern, particularly in situations related to organ transplantation.

A burden falls upon the resources of society when a client's behavior contributes to an illness or injury. Treating the client who drives without a seatbelt and is injured in a motor vehicle accident imposes an economic burden on society. This is so even if the client can afford to pay for his or her medical expenses or has health insurance to pay for care. The actual care provided to one client requires time and energy to support that care despite the cost, and the time it takes to provide care reduces the time that can be devoted to another client. Is it not the responsibility of citizens to comply with laws to decrease this burden? Does this interfere with a person's rights?

Similarly, obese clients who choose not to take measures to lose weight may be in danger of ill health because of this choice. Obese clients are at higher risk for hypertension, adult-onset diabetes, and heart disease. The need for treatment of health problems that are directly or indirectly caused by such clients' decisions places an economic burden on the healthcare system, just like the burden imposed by the driver who refuses to wear a seatbelt and experiences a traumatic injury. Being able to pay for care does not burden the system less, yet the wealthy obese person or the wealthy smoker or alcoholic has a better chance of receiving care or services than the person with fewer economic resources.

Organ transplant allocation becomes an ethical dilemma for some. Organ procurement, along with the issue of limited organ availability and selection of who gets an organ, is a difficult decision in many cases. The sale of organs is illegal in the United States, but not internationally. Should the person who can afford to purchase an organ have preference over one who cannot? At this moment in the United States, individuals must directly give permission before donating an organ or indicate on a document (such as an advance directive or on their driving license) that they will permit their organs to be donated, but cannot decide to whom the organ goes in most cases. Patients must be officially brain dead before most organs can be taken, although kidney and liver donations may be allocated to a designated individual for living donation.

The client's right to self-determination poses another ethical dilemma that may affect the healthcare system. Individuals have the right to make their own decisions. However, if a client chooses not to follow a healthcare provider's healthcare plan at any level of prevention when that plan is based upon research, should the client be considered to be noncompliant or to be using his or her own judgment or values to make an independent decision? Clients may choose not to follow the suggestions or plan of the healthcare provider. Indeed, clients have a right to choose their own care and decide most issues related to their own health, as long as that choice does no harm to others. However, the cost to the healthcare system may be great and in some situations may do harm inadvertently to others.

Personal and Social Responsibility

In the United States, an individual’s right to liberty is protected by the U.S. Constitution and can be affected by disclosure by a health professional. Consider a situation in which a client with an active case of tuberculosis refuses treatment, yet continues living in close proximity to young children. Such a case confronts the nurse with ethical, safety, and legal dilemmas. The nurse must choose between issues related to confidentiality and safety issues—that is, the nurse must weigh the safety of one client against the confidentiality of another. The nurse faces an ethical dilemma when client confidentiality clashes with the obligation to obey laws directed by society. This situation requires that the nurse obey the law by reporting the situation to the health department and breaking the seal of patient confidentiality with the client to whom he or she is committed by the code of the profession. The CHN may face these kinds of conflicting ethical choices on a regular basis (ANA, 2001; Butts & Rich, 2005).

The Health Insurance Portability and Accountability Act

The **Health Insurance Portability and Accountability Act (HIPAA)** was enacted in 1996 and signed into law by President Bill Clinton. It identifies requirements for protection of confidentiality of information related to medical records and services. The original intent was to stop healthcare fraud and enforce healthcare confidentiality and to create health insurance portability and management. Furthermore, HIPAA protects information related to a person’s health care, authorizes release of healthcare information by patients, and clarifies ownership of their health records. The privacy requirements limit the release of patient information without the patient’s consent or knowledge, thereby preventing access to a person’s healthcare information without that individual’s consent. The increased use of electronic records makes HIPAA regulations particularly important for the privacy and security of patient records that reside on shared computer systems (Sheldon, 2009).

Ethical Decisions of the Community Health Nurse

Using the ethical decision-making process, the nurse assists the client in developing a plan of care. **Table 2-2** compares the nursing process and the ethical decision-making process. Both processes are used to move a client problem from assessment through evaluation, so as to best meet the client’s needs. Ethical decision making does not occur

Health Insurance Portability and Accountability Act (HIPAA): Federal legislation enacted in 1996 that identifies requirements for protection of confidentiality of information related to medical records and services. It protects information related to a person’s health care, authorizes release of healthcare information by patients, and clarifies ownership of their health records.

TABLE 2-2
Comparison of the Nursing Process and the Ethical Decision-Making Process

| Nursing Process | Ethical Decision-Making Process |
|---------------------------|---|
| 1. Assessment | 1. Assessment—gathering of relevant information |
| 2. Diagnosis and analysis | 2. Clarification of ethical component and social and legal implications |
| 3. Plan | 3. Identifying possible outcomes |
| 4. Implementation | 4. Implementation |
| 5. Evaluation | 5. Evaluation |



in a vacuum; rather, the CHN works with other providers to solve ethical dilemmas. Agencies in the community, such as acute care facilities, may establish ethics committees to help resolve ethical problems. A critical part of both approaches is the incorporation of cultural beliefs so that the client can participate fully in the healthcare process.

A Cultural Context for Care in the Community

The Influence of Health Beliefs and Culture on Health Care

The impact and influence of cultural and ethical beliefs on the provision of health care in a society are great. Differences in customs and values influence healthcare beliefs and practices among different cultures; regardless of how healthcare professionals evaluate a client's state of health, clients are inclined to measure their own sense of well-being based on their beliefs and values (Raholm, 2008). The way people assess health is highly individual and often has strong ties to culture. In some cases, a client's cultural beliefs or behaviors may conflict with the standards of the healthcare providers in a community. Nonetheless, the responsibility for acquiring health care and maintaining one's personal health is largely placed upon the individual (Andrews & Boyle, 2008).

Placing the burden of responsibility upon the individual for maintaining his or her own health suggests that there is a common standard of acceptable health in the United States. Therefore, self-care becomes an additional responsibility of one's health maintenance. In the United States, many consider health care to be a right, but it is also considered to be a responsibility by many clients and providers.

The CHN may experience a sense of conflict when working with clients who, based on certain societal expectations, have not done all they could to maintain their health. Furthermore, the CHN's response to a client's health needs or demands is inevitably influenced by the nurse's own cultural heritage and health beliefs. Healthcare providers must be sensitive to the enormous impact of culture both on clients' health and on providers' attitudes toward clients.

Culture is learned from a person's environment, and cultural learning is often likened to the way in which humans learn to speak (Spector, 2008). Accordingly, cultural norms are mostly implied and are often unexpressed by individuals. Most members of a family or cultural group have no need to discuss rules among themselves related to their culturally connected behaviors. Culture influences the foods we eat, how our children are reared, how we react to pain, how we cope with stress, how we respond to health care, and how we deal with issues related to death. Cultural influences and organized support systems often set guidelines for living and provide foundations for client behaviors (Andrews & Boyle, 2008; Ray, 2010). In short, culture provides the underpinnings for a person's social development.

Health beliefs or mores are not limited to cultural beliefs. They often incorporate what clients have learned to expect from their social environment (environmental press). Perceptions of health that clients have also reflect the environment in which they live as well as the culture into which they have been socialized. Although ethnic differences are often key to the care of the client, health beliefs frequently organize and manipulate how individuals interpret their own health and how they seek access to health care. Therefore, clients may believe

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that certain conditions are the norm for their age or condition and see no reason to seek out health assistance.

Cultural diversity is found in geographic environments in which a variety of culturally different persons or groups live together. Each group brings its own expectations of health into the larger society. These expectations are, in turn, influenced by a variety of forces, including changes in technology, advancements made in health care, and the influence or pressures from the environment of the greater society. All of these forces shape individuals' interpretation of their rights as members of a society and may create ethical dilemmas within a society (National Center for Cultural Competence, 2006; Purnell, 2009).

The United States for many years was likened to a melting pot, but it is actually more like a salad bowl—that is, it is a mix of people with many groups maintaining their own cultural, ethical, and religious identities and histories, making up one country (**FIGURE 2-3**). Thus, when considering an ethical approach to health care (particularly in the community), one must account for the impact of culture and the values of the members of a community. A more contemporary approach to consider when exploring ethics and community practice is to move away from the traditional approach, which focuses on the individual, and to address the targets of health care at an aggregate, community, or societal level.



Figure 2-3 American culture as a salad with unique ingredients, not a “melting pot.”

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Cultural Variations in Social Interaction

Culture influences how the CHN approaches clients in relation to time and space. **Ethical pluralism** (also known as moral diversity) maintains the position that culturally diverse societies display multiple moral standards, which may lead to conflicting moral realities (Purnell, 2009). However, divergence in values and differences in moral standards across cultural boundaries are valued and considered to be resources that have historically led to the evolution of moral thinking (Dayer-Berenson, 2011, pp. 56–57).

In the United States, persons from the dominant culture tend to be very time dependent and, therefore, very concerned with the importance of time—that is, most Americans set appointments and are disturbed if the person with whom they have an appointment is late. Time is cut up into segments, with work scheduled between the hours of 9 A.M. and 5 P.M., and entertainment similarly kept to a prescribed schedule. Television shows are divided into 30- or 60-minute segments; theater or film begins at a specific time. Because Western culture tends to connote time with productivity, time is regarded as an important commodity. Accordingly, most Americans try to never waste time and to be on time for appointments.


What has just been said about mainstream American culture is not true of all the diverse cultures within the United States, however. Some cultures view time as never ending, and they get to where they are going when they get there. If something does not get finished today, it is believed that it will get done tomorrow. Persons from such cultures have a different approach to keeping appointments and a different understanding of what it means to be “on time.” For persons from Ghana, for example, punctuality is of little importance. It is more important to continue a social interaction than to be on time for another event.

The physical distance people maintain when interacting also differs from culture to culture. In the United States, people from the dominant culture remain approximately 2 feet away from persons with whom they are conversing. In contrast to this practice, persons from many other cultures stand either closer to or farther away from the person with whom they are speaking. Other cultural practices, such as those related to human touch, can also play an important part in how the CHN should approach a client from the nondominant culture. Additionally, eye contact has a significant meaning in most cultures. Many persons native to the Australian culture, for example, may combine direct eye contact with intermittent looking away, which they interpret as showing interest. Although direct eye contact may not be sustained by Native Australians, Argentines tend to maintain intense eye contact during conversation. In short, cultural variation is the rule in the area of social interaction.

The degree to which physical touching is permitted is also dictated by cultural values and mores. While some degree of touching between persons of different sexes is generally acceptable to the dominant culture in the United States, Orthodox Jewish men are not permitted to be touched by women other than their wives. If hands-on care is to be delivered to an Orthodox Jewish male, the CHN delivering the care should also be a man whenever possible. If the CHN is a woman, she should instruct the wife or another man as to how to provide direct care to these male clients at home. The female nurse may oversee procedures to ensure that they are done correctly. South Korean clients also consider physical touching by members of the opposite sex inappropriate.

In Singapore and Vietnam, the head is considered sacred; thus, it is considered an affront to reach over someone’s head and an offense to pat or touch a child on the head (Geissler, 1994). Strangers touching children is frankly frowned upon by many Hispanic parents (Andrews & Boyle, 2008), as Mexican parents believe that such behavior can cause illness. For example, *caída de la mollera* is a serious illness with a high mortality among infants and children 1 to 3 years of age. Its cause is often related to diarrhea or vomiting; as a result of dehydration, the anterior fontanelle becomes depressed below the contour

Ethical pluralism: The position that culturally diverse societies display multiple moral standards, which may lead to conflicting moral realities; also known as moral diversity.



of the skull. Some poorly educated or rural Hispanic parents believe that this condition is caused by a nonfamily member touching the head of the infant. As it is common for the CHN to measure infants' skulls, this procedure is easily mistaken for the cause of the problem (Spector, 2008). If *caida de la mollera* afflicts a child, a **curandero** (folk healer) may be called to rid the child of the *mal ojo* (evil eye) attributable to the stranger. In an attempt to heal the child, the curandero may hold the infant upside down to help the fontanelle resume its correct placement; sadly, this practice may result in retinal hemorrhages. To prevent such tragedies, the parents must be encouraged to hydrate the infant. If they wish to use the curandero, such services can be provided in addition to hydration.

Curandero: A folk healer within Hispanic cultures.

In fact, regardless of their level of education and assimilation into a more cosmopolitan health system, many Mexican Americans and other Hispanics may use the curandero for a variety of ailments and problems. Often these problems may be psychosocial. It is important for the CHN to understand the role and functions of the folk healers and work collaboratively with them. Without acceptance by the folk healer, Hispanic clients may not comply with the recommendations of the CHN or other provider.

Folk beliefs regarding illnesses and their cures can be found in all cultures. Nurses who wish to be optimally effective within the communities they serve should develop familiarity with and appreciation of folk beliefs and other cultural differences, thereby empowering themselves to help their clients toward wellness.

Cultural Sensitivity of the Community Health Nurse

In an effort to reflect cultural sensitivity, the CHN can assist clients in adapting to the care environment in the community. The CHN should explain all schedules and expectations, and ask clients if they understand and can comply with the plan of care. Asking clients about their preferences in care needs to include a clear explanation when client requests cannot be met. Open-ended questions and statements will elicit the most useful information for the CHN to use and incorporate into the plan of care.

Anticipatory guidance is a tool that is useful in supporting the client as he or she adapts to the requirements of the healthcare system. As always, obtaining input from family members and significant others is a critical aspect of providing care. Taking the time to validate the ongoing willingness of the client to participate in his or her care is central to the overall success of moving the client to a higher level of health and wellness. Excellent resources are available from the Health Resources and Services Administration (HRSA) for the CHN to use in examining culture, language, and health literacy. Assessing the response of the community health agency in terms of its cultural sensitivity to client needs allows the CHN to ensure that all providers are working from a culturally sound perspective. This perspective is central to providing anticipatory guidance when meeting the needs of the public (National Center for Cultural Competence, 2006).

Summary

This chapter examined two interrelated concepts—ethics and cultural beliefs. These concepts are related because of their fundamental grounding in the client's personal beliefs and life experience. The first part of the chapter defined ethics and discussed ethical concerns that are central to the practice of community health nursing. These issues include advance directives, quality of life considerations, the cost and rationing of health care, increased use of technology, and the ethical environment in which the CHN practices.

The second part of the chapter examined culture—specifically, the influence of culture on providing and receiving nursing care in the community. In the United States, clients seeking nursing care in the community come from a variety of cultural backgrounds, and the CHN must be aware of and respectful toward all clients' cultural grounding.

When working with some individuals from nondominant cultures, understanding the importance of culture is the key to developing a therapeutic and lasting nurse–client relationship. A strong ethical foundation and cultural appreciation of how to best meet the needs of the community are central to professional nursing practice.

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LEARNING ACTIVITIES

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1. The Code of Ethics, which set the standards for ethical nursing behavior, was developed by which of the following organizations?
 - A. U.S. Department of Health and Human Services
 - B. National League for Nursing
 - C. American Nurses Association
 - D. The Joint Commission
2. The obligation of the healthcare professional to “do good” is represented by which of the following principles?
 - A. Beneficence
 - B. Justice
 - C. Nonmaleficence
 - D. Confidentiality
3. After the nurse carefully explains the implications of identifying a “healthcare proxy” and the meaning of instituting a “do not resuscitate” medical order, Ms. Jones, a 96-year-old patient with congestive heart failure, who is mentally competent, refuses to participate in any further discussion of the topics. Which of the following statements, made by a nurse, is probably correct?
 - A. “Ms. Jones is making a mistake she will regret.”
 - B. “The staff should call Ms. Jones’s family and encourage her to change her mind.”
 - C. “This is Ms. Jones’s decision and needs to be respected.”
 - D. “Ms. Jones’s physician will have to serve as healthcare proxy in this situation.”
4. Which statement made by a nurse to a client refers to the concept of autonomy?
 - A. “It is a person’s right to independence or self-determination.”
 - B. “It refers to the right of a society, not the right of an individual.”
 - C. “It relates to individuals’ freedom to do whatever they want concerning their health.”
 - D. “It is the individual’s responsibility to do the right thing to improve his or her own destiny.”
5. What is the goal of the Health Insurance Portability and Accountability Act (HIPAA) ?
 - A. The act protects the integrity of Medicaid and Medicare information shared with other agencies.
 - B. The act protects the client against disclosure of identifiable health information.
 - C. The act restricts sharing of health information with unregulated insurance companies.
 - D. The act is primarily intended to control electronic health records.



ADDITIONAL QUESTIONS FOR STUDY

1. Our values are influenced by many things. Develop a brief overview of what you believe has affected your personal values related to health care, and then create a list of what you believe has or will affect your professional values.
2. Pretend that you have won \$1 million in the lottery. List the first three items on which you would spend your money (e.g., pay off loans, share with family, take a trip or vacation, retire). Share with your classmates how, as a group, you would spend the money. Keep track of each item and determine whether they are repeated by others. This is an indication of what you value.
3. Identify three nursing or healthcare problems you would like to solve with part of your winnings from the lottery (see Question 2). Share the information with classmates as suggested in Question 2.