

Foundations of Ethical Nursing Practice

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Scientific and technological advances, economic realities, pluralistic worldviews, and global communication make it impossible for nurses to ignore important ethical issues in the world community, their individual lives, and their work. As controversial and sensitive ethical issues continue to challenge nurses and other healthcare professionals, many professionals have begun to develop an appreciation for personal philosophies of ethics and the diverse viewpoints of others.

Often ethical directives are not clearly evident, which leads some people to argue that ethics can be based merely on personal opinions. However, if nurses are to enter into the global dialogue about ethics, they must do more than practice ethics based simply on their personal opinions, their intuition, or the unexamined beliefs that are proposed by other people. It is important for nurses to have a basic understanding of the various concepts, theories, approaches, and principles used in ethics throughout history and to identify and analyze ethical issues and dilemmas that are relevant to nurses in this century. Mature ethical sensitivities are critical to professional nursing practice.

Key Terms and Concepts

- » **Ethics**
- » **Morals**
- » **Bioethics**
- » **Nursing ethics**
- » **Moral reasoning**
- » **Wholeness of character**
- » **Integrity**
- » **Basic dignity**
- » **Personal dignity**
- » **Virtues**
- » **Deontology**
- » **Utilitarianism**
- » **Ethic of care**
- » **Ethical principlism**
- » **Autonomy**
- » **Beneficence**
- » **Paternalism**
- » **Nonmaleficence**
- » **Justice**
- » **Ethical dilemma**
- » **Moral suffering**

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Learning Objectives

After completing this chapter, the student should be able to:

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1. Discuss the meaning of key terms associated with ethical nursing practice.
2. Compare and contrast ethical theories and approaches that might be used in nursing practice.
3. Discuss each of the popular bioethical principles as they relate to nursing practice: autonomy, beneficence, nonmaleficence, and justice.
4. Justify the importance of the *Code of Ethics for Nurses* for professional nursing practice.
5. Explain how nurses can identify and analyze dilemmas that occur in nursing practice.

Ethics in Everyday Life

Ethics, a branch of philosophy, means different things to different people. When the term is narrowly defined according to its original use, ethics is the study of ideal human behavior and ideal ways of being. The approaches to ethics and the meanings of ethically related concepts have varied over time among philosophers and ethicists. As a philosophical discipline of study, ethics is a systematic approach to understanding, analyzing, and distinguishing matters of right and wrong, good and bad, and admirable and deplorable as they exist along a continuum and as they relate to the well-being of and the relationships among sentient beings. Ethical determinations are applied through the use of formal theories, approaches, and codes of conduct.

Mature ethical sensitivities are critical to professional nursing practice.

As contrasted with the term *ethics*, **morals** are specific beliefs, behaviors, and ways of being based on personal judgments derived from one's ethics. One's morals are judged to be good or bad through systematic ethical analysis. Because the word *ethics* is used when one might literally be referring to a situation of morals, the process-related conception of ethics is sometimes overlooked today. People often use the word *ethics* when referring to a collection of actual beliefs and behaviors, thereby using the terms *ethics* and *morals* in essentially synonymous ways.

Bioethics

The terms *bioethics* and *healthcare ethics* are sometimes used interchangeably in the literature. **Bioethics** is a specific domain of ethics that is focused on moral issues in the field of health care. Callahan (1995) calls it “the intersection of ethics and the life sciences—but also an academic discipline” (p. 248). Bioethics has evolved into a discipline all its own as a result of life-and-death moral dilemmas encountered by physicians, nurses, other healthcare professionals, patients, and families.

In his book *The Birth of Bioethics*, Albert Jonsen (1998) designates a span of 40 years, from 1947 to 1987, as the era when bioethics was evolving as a discipline. This era began with the Nuremberg Tribunal in 1947, when Nazi physicians were charged and convicted for the murderous and tortuous war crimes that these physicians labeled as scientific experiments during the early 1940s. The 10 judgments in the final court ruling of the Nazi trial provided the basis for the worldwide Nuremberg Code of 1947. This code became a document to protect human subjects during research and experimentation.

The 1950s and 1960s were preliminary years before the actual birth of bioethics. A transformation was occurring during these years as technology

advanced. In this era, a new ethic was emerging about life and extension of life through technology. The development of the polio vaccine, organ transplantation, life support, and many other advances occurred. Scientists and physicians were forced to ask questions: “Who should live?” “Who should die?” “Who should decide?” (Jonsen, 1998, p. 11). Many conferences and workshops during the 1960s and 1970s addressed issues surrounding life and death.

By 1970, the public, physicians, and researchers were referring to these phenomena as bioethics (Johnstone, 1999). Today, bioethics is a vast interdisciplinary venture that has engrossed the public’s interest from the time of its conception. The aim of bioethicists today is to continue to search for answers to deep philosophical questions about life, death, and the significance of human beings and to help guide and control public policy (Kuhse & Singer, 1998).

Nursing Ethics

“It is the real-life, flesh-and-blood cases that raise fundamental ethical questions” (Fry & Veatch, 2000, p. 1) in nursing. **Nursing ethics** sometimes is viewed as a subcategory of the broader domain of bioethics, just as medical ethics is a subcategory of bioethics. However, controversy continues about whether nursing has unique moral problems in professional practice. Nursing ethics, similar to all healthcare ethics, usually begins with cases or problems that are practice based.

Many nursing ethicists distinguish issues of nursing ethics from broader bioethical issues that nurses encounter. These nursing ethicists view nursing ethics as a separate field because of the unique variety of ethical problems that surface in relationships between nurses and patients, families, physicians, and other professionals who are a part of the healthcare team. The key criteria for distinguishing issues of nursing ethics from bioethics are that nurses are the primary agents in the scenario, and ethical issues are viewed from a nursing rather than a medical perspective.

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Moral Reasoning

In general, reasoning involves using abstract thought processes to solve problems and to formulate plans (Angeles, 1992). More specifically, **moral reasoning** pertains to making decisions about how humans ought to be and act. Deliberations about moral reasoning go back to the days of the ancient Greeks when Aristotle (Broadie, 2002), in *Nicomachean Ethics*, discussed the intellectual virtue of wisdom as being necessary for deliberation about what is good and advantageous in terms of moving toward worthy ends (Broadie, 2002).

Moral reasoning can be described by what Aristotle (Broadie, 2002) called the intellectual virtue of wisdom (phronesis), also known as prudence. Virtue is an excellence of intellect or character. The virtue of wisdom is focused on the good achieved from being wise, that is, knowing how to act in a particular situation, practicing good deliberation, and having a disposition consistent with excellence of character (Broadie, 2002). Therefore, prudence involves more than having good intentions or meaning well. It includes knowing “what is what” but also transforming that knowledge into well-reasoned decisions. Deliberation, judgment, and decision are the steps in transforming knowledge into action. Prudence becomes truth in action (Pieper, 1966).

In more recent times, Lawrence Kohlberg, in 1981, reported his landmark research about moral reasoning based on 84 boys who he had followed for more than 20 years. Kohlberg defined six stages ranging from immature to mature moral development. Interestingly, Kohlberg did not include any women in his research but expected that his six-stage scale could be used to measure moral development in both males and females. When the scale was applied to women, they seemed to score only at the third stage of the sequence, a stage in which Kohlberg described morality in terms of interpersonal relationships and helping others. Kohlberg viewed this third stage of development as deficient in regard to mature moral reasoning.

In light of Kohlberg’s exclusion of females in his research and the negative implications of women being placed within the third stage of moral reasoning, Carol Gilligan raised the concern of gender bias. Gilligan, in turn, published an influential book in 1982, *In a Different Voice*, in which she argued that women’s moral reasoning is different but is not deficient (Gilligan, 1993; Grimshaw, 1993; Thomas, 1993). The distinction that is usually made between the ethics of Kohlberg and Gilligan is that Kohlberg’s is a male-oriented ethic of justice and Gilligan’s is a more feminine ethic of care. The Kohlberg–Gilligan justice–care debate is still at the heart of feminist ethics.

Often the work of nurses does not involve independent moral reasoning and decision making in regard to the well-publicized issues in bioethics, such as withdrawing life support. Independent moral reasoning and decision making for nurses usually occurs more in the day-to-day care and relationships between nurses and their patients and between nurses and their coworkers. Nurses’ moral reasoning is similar to the findings of Gilligan and is often based on caring and the needs of good interpersonal relationships. However, this does not negate what nurses can learn from studying Aristotle and his virtue of phronesis. Nurses’ moral reasoning needs to be deliberate and practically wise to facilitate patients’ well-being.

Values in Nursing

Values are emphasized in the American Nurses Association (ANA, 2001) *Code of Ethics for Nurses with Interpretive Statements*. *Values* refer to a

group's or individual's evaluative judgments about what is good or what makes something desirable. Professional values are integral to moral reasoning. Values in nursing encompass appreciating what is important for both the profession and nurses personally, as well as what is important for patients.

In the *Code of Ethics for Nurses with Interpretive Statements* (discussed in more detail later in this chapter), the ANA (2001) includes statements about **wholeness of character**, which pertains to knowing the values of the nursing profession and one's own authentic moral values, integrating these two belief systems, and expressing them appropriately. **Integrity** is an important feature of wholeness of character. According to the code, maintaining integrity involves acting consistently with personal values and the values of the profession. In a healthcare system often

burdened with constraints and self-serving groups and organizations, threats to integrity can be a serious pitfall for nurses. When nurses are asked and pressured to do things that conflict with their values, such as to falsify records, deceive patients, or accept verbal abuse from others, emotional and moral suffering can occur. A nurse's values must guide moral reasoning and actions, even when other people challenge the nurse's beliefs. When compromise is necessary, the compromise must not be such that it compromises personal or professional values.

Recognizing the essential dignity of oneself and each patient is another value that is basic to nursing and is given priority in moral reasoning. Pullman (1999) describes two conceptions of dignity. One type, called **basic dignity**, is intrinsic, or inherent, and dwells within all humans, with all humans being ascribed this moral worth. The other type, called **personal dignity**, often mistakenly equated with autonomy, is an evaluative type. Judging others and describing behaviors as dignified or undignified are of an evaluative nature. Personal dignity is a socially constructed concept that fluctuates in value from community to community, as well as globally. Most often, however, personal dignity is highly valued.

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Ethical Theories and Approaches

Within each ethical theory or approach, a normative framework exists that includes foundational statements. Individuals who apply a particular theory or approach know what beliefs and values are right and wrong and what is and is not acceptable according to the particular ethical system. Normative ethical theories function as moral guides in answering the question: "What ought I do or not do?" Theory helps to provide guidance in moral thinking and reasoning and justification for moral actions. Optimally, ethical theories and approaches should

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help people to discern commonplace morality and strengthen moral judgments “in the face of moral dilemmas” (Mappes & DeGrazia, 2001, p. 5).

■ Virtue Ethics

Since the time of Aristotle (384–322 B.C.), **virtues**, *arête* in Greek, refer to excellences of intellect or character. Aristotle, the Greek philosopher, was one of the most influential thinkers in regard to virtue ethics. Virtue ethics pertains to questions of “What sort of person must I be to achieve my life’s purpose?” and “What makes one a good or excellent person?” rather than “what is right or good to do based on my duty or to achieve good consequences?” Virtues are intellectual and character traits or habits that are developed throughout one’s life. The idea behind virtue ethics is that when people are faced with complex moral dilemmas or situations, they will choose the right course of action because doing the right thing comes from a virtuous person’s basic character. Aristotle believed that for a person to develop moral character, personal effort, training, and practice must occur. Examples of virtues include benevolence, compassion, courage, justice, generosity, truthfulness, wisdom, and patience.

■ Natural Law Theory

Saint Thomas Aquinas (1225–1274), who had a great influence on natural law theory as disseminated by Roman Catholic writers of that century, was himself influenced by Aristotle’s work. Most versions of natural law theory today have their basis in Aquinas’s basic philosophy. According to natural law theory, the rightness of actions is self-evident from the laws of nature, which in most cases is orchestrated by a law-giver God. Morality is determined not by customs and human preferences but is commanded by the law of reason, which is implanted in nature and human intellect. Natural law ethicists believe that behavior that is contrary to their views of the laws of nature is immoral. Examples include artificial means of birth control and homosexual relationships.

■ Deontology

Deontology refers to actions that are duty based, not based on their rewards, happiness, or consequences. One of the most influential philosophers for the deontologic way of thinking was Immanuel Kant, an 18th-century German philosopher. In his classic work, *Groundwork of the Metaphysics of Morals*, Kant (1785/2003) attempted to define a person as a rational human being with freedom, moral worth, and ideally having a good will, meaning that a person should act from a sense of duty. Because of their rationality, Kant believed, humans have the freedom to make moral judgments. Therefore, Kant argued that people ought to follow a universal framework of moral maxims,

or rules, to guide right actions because it is only through performing dutiful actions that people have moral worth. Even when individuals do not want to act from duty, Kant stated that they are required to do so if they want to be ethical. Maxims apply to everyone universally and become the laws for guiding conduct. According to Kant, moral actions should be ends in themselves, not the means to ends. In fact, when people use others as a means to an end, such as deliberately using another person to reach one's personal goals, they are not treating other people with the dignity that they deserve.

Kant distinguished between two types of duties: hypothetical imperatives and categorical imperatives. Hypothetical imperatives are duties or rules that people ought to observe if certain ends are to be achieved. Hypothetical imperatives are sometimes called "if-then" imperatives, which are conditional: for instance, "If I want to pass my nursing course, then I should be diligent in my studies."

However, Kant stated that moral actions must be based on unconditional reasoning. Where moral actions are concerned, duties and laws are absolute and universal. Kant called these moral maxims, or duties, categorical imperatives. When acting according to a categorical imperative, one should ask this question: "If I perform this action, would I will that it becomes a universal law?" No action can ever be judged as right, according to Kant, if the action cannot have the potential to become a binding law for all people. For example, Kant's ethics would impose the categorical imperative that one can never tell a lie for any reason because if a person lies in any instance, the person cannot rationally wish that permission to lie should universally become a law for everyone.

■ Utilitarianism

Contrasted with deontology, the ethical approach of **utilitarianism** is to promote the greatest good that is possible in situations (i.e., the greatest good for the greatest number). British utilitarianism was promoted by Jeremy Bentham (1789/1988) in his book *An Introduction to the Principles of Morals and Legislation*. Bentham's thoughts on utilitarianism were that each form of happiness is equal and that each situation or action should be evaluated according to its production of happiness, good, or pleasure. John Stuart Mill (1863/2002) challenged Bentham's view when in his book, *Utilitarianism*, he clearly points out that experiences of pleasure and happiness do have different qualities and are not equal. For example, Mill stated that intellectual pleasures of humans have more value than physical pleasures of nonhuman animals.

Utilitarians place great emphasis on what is best for groups, not individual people. In doing so, the focus is on moral acts that produce the most good in terms of the most happiness. By aiming for the most happiness, this theory focuses on good consequences, utility (usefulness), or good ends. Although happiness is the goal, it should be kept in mind that utilitarianism is not based

merely on subjective preferences or judgments of happiness. Commonsense ethical directives agreed upon by groups of people are usually applied.

■ Ethic of Care

The **ethic of care** has a history in feminist ethics, which has a focus in the moral experiences of women. In the ethic of care approach, personal relationships and relationship responsibilities are emphasized. Important concepts in this approach are compassion, empathy, sympathy, concern for others, and caring for others. Carol Gilligan with her study on gender differences in moral development (see the Moral Reasoning section earlier in this chapter) has had an influence on the ethic of care approach.

www CRITICAL THINKING QUESTIONS ★

Think about the ethical theories and approaches discussed in this section and think about moral conflicts you have experienced in the past. Have you used one of these approaches to resolve a conflict? Which approach or approaches have you used? ★

People who uphold the ethic of care think in terms of particular situations and individual contexts, not in terms of impersonal universal rules and principles. In resolving moral conflicts and understanding a complex situation, a person must use critical thinking to inquire about relationships, circumstances, and the problem at hand. The situation must be brought to light with “caring, consideration, understanding, generosity, sympathy, helpfulness, and a willingness to assume responsibility” (Munson, 2004, p. 788).

■ Ethical Principlism

Ethical principlism, a popular approach to ethics in health care, involves using a set of ethical principles that is drawn from the common or widely shared conception of morality. The four principles that are most commonly used in bioethics are autonomy, beneficence, nonmaleficence, and justice. In 1979, Tom Beauchamp and James Childress published the first edition of *Principles of Biomedical Ethics*, which featured these four principles. Currently, the book is in its sixth edition, and the four principles have become an essential foundation for analyzing and resolving bioethical problems.

These principles, which are closely associated with rule-based ethics, provide a framework to support moral behavior and decision making. However, the principles neither form a theory nor provide a well-defined decision-making model. The framework of principlism provides a *prima facie* model. As a *prima facie* model, principles are applied based on rules and justifications for moral behavior. Often, more than one principle is relevant in ethical situations, and no conflict occurs. However, if relevant principles conflict in any situation, judgment must be used in weighing which principle should take precedence in guiding actions.

The four principles that are most commonly used in bioethics are autonomy, beneficence, nonmaleficence, and justice.

Autonomy

The word *autonomy* is a derivative of “the Greek *autos* (‘self’) and *nomos* (‘rule, governance, or law’)” (Beauchamp & Childress, 2009, p. 99). **Autonomy** then involves one’s ability to self-rule and to generate personal decisions independently. Some people argue that autonomy has a top priority among the four principles. However, there is no general consensus about this issue, and many people argue that other principles, such as beneficence, should take priority. Ideally, when using a framework of principlism, no one principle should automatically be assumed to rule supreme.

The principle of autonomy sometimes is described as respect for autonomy (Beauchamp & Childress, 2009). In the domain of health care, respect for a patient’s autonomy includes situations such as obtaining informed consent for treatment; facilitating patient choice regarding treatment options; accepting patients’ refusal of treatment; disclosing medical information, diagnoses, and treatment options to patients; and maintaining confidentiality. It is important to note that a patient’s right to respect for autonomy is not unqualified. In cases of endangering or harming others, for example, through communicable diseases or acts of violence, people lose their basic rights to self-determination.

Beneficence

The principle of **beneficence** consists of deeds of “mercy, kindness, and charity” (Beauchamp & Childress, 2001, p. 166). Beneficence in nursing implies that nurses take actions to benefit patients and to facilitate their well-being. Beneficent nursing actions include obvious interventions such as lifting side rails on the patient’s bed to prevent falls. More subtle actions also might be considered to be beneficent and kind actions, such as taking time to make phone calls for a frail, older patient who is unable to do so herself.

Occasionally, nurses can experience ethical conflicts when confronted with having to make a choice between respecting a patient’s right to self-determination (autonomy) and the principle of beneficence. Nurses might decide to act in ways that they believe are for a patient’s “own good” rather than allowing patients to exercise their autonomy. The deliberate overriding of a patient’s autonomy in this way is called **paternalism**. An example of a paternalistic action is for a nurse to decide that a patient must try to ambulate in the hall, even though the patient moans and complains of being too tired from his morning whirlpool treatment. In that case, the nurse is aware that the patient wants to wait until a later time but insists otherwise. Nurses must weigh carefully the value of paternalistic actions and determine whether they are truly in the patient’s best interest. Justified paternalism often involves matters of patient safety.

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COMPETENCY BOX 4-1

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Professionalism:

Attitudes/Behaviors (A7a)
Values the application of
ethical principles in daily
practice

Source: Massachusetts Department
of Higher Education (2010, p. 14).

Nonmaleficence

Nonmaleficence, the injunction to “do no harm,” is often paired with beneficence, but a difference exists between the two principles. Beneficence requires taking action to benefit others, whereas nonmaleficence involves refraining from action that might harm others. Nonmaleficence has a wide scope of implications in health care that includes most notably avoiding negligent care, as well as making decisions regarding withholding or withdrawing treatment and regarding the provision of extraordinary or heroic treatment.

Justice

The fourth major principle, **justice**, is a principle in healthcare ethics, a virtue, and the foundation of a duty-based ethical framework of moral reasoning. In other words, the concept of justice is quite broad in the field of ethics. Justice refers to the fair distribution of benefits and burdens. In regard to principlism, justice most often refers to the distribution of scarce healthcare resources. Most of the time, difficult resource allocation decisions are based on attempts to answer questions regarding who has a right to health care and who will pay for healthcare costs.

Professional Ethics and Codes

Professional nursing began in England in the 1800s at the school Florence Nightingale founded, where profession-shaping ethical precepts were communicated (Kuhse & Singer, 1998). Nightingale’s achievement was a landmark in nursing even though graduates in the early days of the school were below average (Dossey, 2000). For the first 30 to 40 years in Nightingale’s school, male physicians trained the probationers because not enough educated women were available to teach nursing. Because of this strong medical influence, early nursing education was focused on technical training rather than on the art and science of nursing as Nightingale would have preferred.

By the end of the 1800s, modern nursing was established, and by the early 1890s, ethics in nursing was being discussed seriously (Dossey, 2000; Kuhse & Singer, 1998). The Nightingale Pledge, first administered in 1893, was written under the chairmanship of Lystra Gretter, the principal of a Detroit nursing school, and the origination of the pledge helped to establish nursing as an art and a science (Dossey, 2000). The International Council of Nurses (ICN), which has been a pioneer in developing a code of nursing ethics, was established in 1899. By 1900, the first book on nursing ethics, *Nursing Ethics: For Hospital and Private Use*, was written by the American nursing leader Isabel Hampton Robb (Kuhse & Singer, 1998).

Historically, a primary consideration in nursing ethics has been the determination of who is the focus of nurses’ work. Until the 1960s, this focus was on the physician, which is not surprising based on the fact that over the years

most nurses have been women and most doctors have been men (Kuhse & Singer, 1998). The focus on nurses' obedience to physicians remained at the forefront of nursing responsibilities into the 1960s with this assumption still being reflected in the *ICN Code of Nursing Ethics* in 1965. By 1973, however, the focus of nurses' primary responsibility within the ICN's code changed from the physician to the patient, where it remains to this day.

No code can provide absolute or complete rules that are free of conflict and ambiguity. Because codes are unable to provide exact directives for ethical decision making and action in all situations, some ethicists believe that virtue ethics provides a better approach to ethics because the emphasis is on an agent's character rather than on rules, principles, and laws (Beauchamp & Childress, 2009). Proponents of virtue ethics consider that if a nurse's character is not virtuous, the nurse cannot be depended on to act in good or moral ways even with a professional code as a guide. Professional codes do serve a useful purpose in providing direction to healthcare professionals. Ultimately, one must remember that codes do not eliminate moral dilemmas and are of no use without professionals' motivation to act morally.

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■ The Code of Ethics for Nurses

The ANA first adopted its code in 1950 (Daly, 2002). Although it has always been implied that the code reflected ethical provisions, the word *ethics* was not added to the title until the 1985 code was replaced with its sixth and latest revision in 2001 (Fowler & Benner, 2001). The ANA's (2001) *Code of Ethics for Nurses* contains general moral provisions and standards for nurses to follow, but specific guidelines for clinical practice, education, research, and administration are contained within the accompanying interpretive statements. See Appendix B for ANA's *Code of Ethics for Nurses*.

The code is considered to be nonnegotiable in regard to nursing practice. Some of the significant positions and changes in the 2001 code include a return to the use of the word *patient*, rather than *client*; an application of the code to nurses in all roles, not just clinical roles; conceding that research is not the only method that contributes to professional development; reaffirming a stance against nurses' participation in euthanasia; emphasizing that nurses owe the same duties to self as to others; and recommending that members who represent nursing associations are responsible for expressing nursing values, maintaining professional integrity, and participating in public policy development (ANA, 2001; Fowler & Benner, 2001).

The ANA Code of Ethics for Nurses is considered to be nonnegotiable in regard to nursing practice.

Fowler (Fowler & Benner, 2001) and Daly (2002), nursing leaders involved in revising the code completed in 2001, have proposed that the new

code is clearly patient focused whether the patient is considered to be “an individual, family, group, or community” (Daly, 2002, p. 98). The nurse’s loyalty must be foremost to the patient even though institutional politics is a frequent influence in today’s nursing environment.

With the expanding role of nurse administrators and advanced practice nurses, each nurse must be cognizant of conflicts of interest that could potentially have a negative effect on relationships with patients and patient care. Often nurses have overlooked the responsibility to the patient by nurses who are not in clinical roles. Nurse researchers, administrators, and educators are indirectly but still involved in affecting patient care. According to Fowler and Benner (2001), “It is not the possession of nursing credentials, degrees, and position that makes a nurse a nurse; rather it is this very commitment to the patient” (p. 435). Therefore, the code applies to all nurses regardless of their role.

One issue that created a vigorous debate with the 2001 revision of the code involved the ethical implications of collective bargaining in nursing (Daly, 2002). Ultimately, the nurses who formulated the revisions decided that it was important for the code to contain provisions supporting nurses who work to ensure that the environment in which they work is conducive to quality patient care and that nurses are able to fulfill their moral requirements. Collective bargaining was determined to be an appropriate avenue for more than just negotiating for better salaries and benefits. It also can be used to improve the moral level of the environment in which nurses work.

■ The ICN Code of Ethics for Nurses

In 1953, the International Council of Nurses (ICN) adopted its first *Code of Ethics for Nurses*. The most recent revision and review of the code occurred in 2006. The code has been revised and reaffirmed many times. The four principal elements contained within the ICN code involve standards related to nurses and people, practice, the profession, and coworkers. These elements form a framework to guide nursing conduct and are elaborated within the code with practice applications for practitioners and managers, educators and researchers, and national nurses’ associations. The *ICN Code of Ethics for Nurses* is available online at www.icn.ch/icncode.pdf.

■ A Common Theme of ANA and ICN Codes

A theme common to the codes of the ANA (2001) and ICN (2006) is a focus on the importance of nurses delivering compassionate patient care aimed at alleviating suffering. This emphasis is threaded throughout the codes but begins with the patient being the central focus of a nurse’s work. Nurses are to support patients in self-determination and are to protect the moral environment in which patients receive care. The interests of various nursing associations and healthcare institutions must not be placed above those of

patients. Although opportunities in the healthcare environment to exhibit compassion are not unique to nurses, nurses must always uphold the moral agreement that they make with communities when they join the nursing profession. Nursing care includes the important responsibilities of promoting health and preventing illness, but the heart of nursing care has always involved caring for patients who are experiencing varying degrees of physical, psychologic, and spiritual suffering.

In the *Code of Ethics for Nurses with Interpretative Statements*, the ANA (2001) emphasizes the importance of moral respect for all human beings, including nurses' respect for themselves. Self-respect also can be thought of as personal regard. Personal regard involves nurses extending attention and care to their own requisite needs. Nurses who do not regard themselves as worthy of care usually cannot fully care for others.

Ethical Analysis and Decision Making in Nursing

Ethical issues and dilemmas are ever present in healthcare settings. Many times, ethical issues are so prevalent in practice that nurses do not even realize that they are making minute-by-minute ethical decisions (Chambliss, 1996; Kelly, 2000). Whether or not they are cognizant of the ethical matters at the time that the decisions are made, nurses use their critical thinking skills to respond to many of these everyday decisions. Personal values, professional values and competencies, ethical principles, and ethical theories and approaches are variables that must be considered when an ethical decision is made. Answers to the questions “What is the right thing to do for my patient?” and “What sort of nurse do I want to be?” are important to professional nursing practice.

■ Ethical Dilemmas and Conflicts

An **ethical dilemma** is a situation in which an individual is compelled to make a choice between two actions that will affect the well-being of a sentient being and both actions can be reasonably justified as being good, neither action is readily justifiable as good, or the goodness of the actions is uncertain. One action must be chosen, thereby generating a quandary for the person or group who must make the choice.

In addition to general, situational ethical dilemmas, dilemmas can arise from conflicts between nurses, other healthcare professionals, the healthcare organization, and

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

COMPETENCY BOX 4-2

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Professionalism:

Attitudes/Behaviors (A7b)
Values acting in accordance
with codes of ethics and
accepted standards of
practice

Skills (S7a) Incorporates
American Nurses Asso-
ciation's *Code of Ethics* into
daily practice; (S7f) Applies
a professional nursing
code of ethics and profes-
sional guidelines to clinical
practice

Source: Massachusetts Department
of Higher Education (2010, p. 14).

Many times, ethical issues are so prevalent in practice that nurses do not even realize that they are making minute-by-minute ethical decisions.

the patient and family. A dilemma might involve nurses making a choice between staying to work an extra shift during a situation of inadequate staffing and going home to rest after a very tiring 8 hours of work. Nurses in this situation might believe that patients will not receive safe or good care if they do not stay to work the extra shift, but these nurses also might not provide safe care if they stay at the hospital because of already being tired from a particularly hard day of work.

■ Moral Suffering

Many times nurses experience disquieting feelings of anguish or uneasiness consistent with what might be called moral suffering. **Moral suffering** can be experienced when nurses attempt to sort out their emotions when they find themselves in situations that are morally unsatisfactory or when forces beyond their control prevent them from influencing or changing these perceived unsatisfactory moral situations. Suffering can occur because nurses believe that situations must be changed to bring well-being to themselves and others or to alleviate the suffering of themselves and others.

Moral suffering can arise, for example, from disagreements with institutional policy, such as a mandatory overtime or on-call policy that nurses believe does not allow adequate time for their psychological well-being. Nurses also might disagree with physicians' orders that the nurses believe are not in patients' best interest, or they might disagree with the way a family treats a patient or makes patient care decisions. These are but a few examples of the many types of encounters that nurses can have with moral suffering.

Another important, but often unacknowledged, source of moral suffering involves nurses freely choosing to act in ways in which they, themselves, know is not morally commendable. A difficult situation that may cause moral suffering for a nurse would be covering up a patient care error made by a valued nurse best friend. On the other hand, nurses might experience moral suffering when they act courageously by doing what they believe is morally right despite anticipated disturbing consequences. Sometimes, doing the right thing or acting as a virtuous person would act is difficult.

Some people view suffering as something to accept and to transform, if possible. Others react to situations with fear, bitterness, and anxiety. It is important to remember that wisdom and inner strength are often most increased during times of greatest difficulty.

www CRITICAL THINKING QUESTION *

Has there ever been a time when you have experienced the dilemma of having to make a choice that you know will affect the well-being of another individual? Have you ever experienced moral suffering? *

■ Using a Team Approach

When trying to navigate ethically laden situations, patients and families can experience extreme anguish and suffering. Physicians, nurses, and other healthcare providers might explain to a patient or family that to continue the

patient's treatment would be nonbeneficial and futile while patients or family members insist on continued treatment. When patients are weakened by disease and illness and families are reacting to the pain and suffering of their loved one, decisions regarding treatment can become sensitive and challenging for everyone concerned. Members of the healthcare team might question the decision-making capacity of the patient or family. The patient's or family's decision might conflict with the physician's or healthcare team's opinions regarding treatment. Nurses who care for patients and interact with families sometimes find themselves caught in the middle of these conflicts.

It is important to note that most problematic ethical decisions in health care are not made unilaterally—not by physicians, nurses, or any other single person. Still, nurses are an integral part of the larger team of decision makers. Although nurses often make ethical decisions independently, many ethical dilemmas require nurses to participate interdependently with others in decision making. In analyzing healthcare ethics and decision making, nurses participate in extensive dialogue with others through committees, clinical team conferences, and other channels. Nurses are part of the larger team approach to ethical analysis. Commonly, the team is called an ethics consultation team or ethics committee.

Members of the team usually are physicians, nurses who represent their patients, an on-staff chaplain, nurses who regularly participate on the consultative team, a social worker, administrative personnel, possibly a legal representative, a representative for the patient in question or surrogate decision maker, and others drafted by the team. The number and membership of the ethics team vary among organizations and specific cases. When ethical disputes arise among any members of a patient's healthcare team, including disputes with patients and families, nurses often are the ones who seek an ethics consultation. It is within the right and duty of nurses to seek help and advice from the team if they encounter moral dilemmas or experience moral suffering.

In healthcare settings, moral reasoning to resolve an ethical dilemma is often a case-based, or bottom-up, inductive, casuistry approach. This approach begins with relevant facts about a particular case and moves toward a resolution through a structured analysis. A practical case-based ethical analysis approach that is used commonly by nurses and other healthcare professionals is the Four Topics Method or, often called in jargon, the 4-Box Approach (Table 4-1) (Jonsen, Siegler, & Winslade, 2006, p. 11). The Four Topics Method, developed by Albert Jonsen, Mark Siegler, and William Winslade, was published first in 1982 in their book *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, which is in its sixth edition.

This case-based approach facilitates critical thinking about the issues and problems of a particular situation and facilitates construction of the case through information gathering in a structured format. Each problematic ethical case is analyzed according to four topics: medical

COMPETENCY BOX 4-1

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Professionalism:

Skills (S7e) Recognizes
moral distress and seeks
resources for resolution

Source: Massachusetts Department
of Higher Education (2010, p. 14).

In healthcare settings, moral reasoning to resolve an ethical dilemma is often a case-based, or bottom-up, inductive, casuistry approach.

Four Topics Method for Analysis in Clinical Ethics Cases

Medical Indications

The Principles of Beneficence and Nonmaleficence

1. What is the patient's medical problem? history? diagnosis? prognosis?
2. Is the problem acute? chronic? critical? emergent? reversible?
3. What are the goals of treatment?
4. What are the probabilities of success?
5. What are the plans in case of therapeutic failure?
6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?

Quality of Life

The Principles of Beneficence and Nonmaleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life?
2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?
5. Is there any plan and rationale to forgo treatment?
6. Are there plans for comfort and palliative care?

Patient Preferences

The Principle of Respect for Autonomy

1. Is the patient mentally capable and legally competent? Is there evidence of incapacity?
2. If competent, what is the patient stating about preferences for treatment?
3. Has the patient been informed of benefits and risks, understood this information, and given consent?
4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
5. Has the patient expressed prior preferences, e.g., advance directives?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

Contextual Features

The Principles of Loyalty and Fairness

1. Are there family issues that might influence treatment decisions?
2. Are there provider (physicians and nurses) issues that might influence treatment decisions?
3. Are there financial and economic factors?
4. Are there religious and cultural factors?
5. Are there limits on confidentiality?
6. Are there problems of allocations of resources?
7. How does the law affect treatment decisions?
8. Is clinical research or teaching involved?
9. Is there any conflict of interest on the part of the providers or the institution?

Source: Jonsen, A. R., Siegler, M., & Winslade, W. J. (2006). *Clinical ethics: A practical approach to ethical decisions in clinical medicine* (6th ed.). New York: McGraw-Hill. Reprinted with permission of The McGraw-Hill Companies.

TABLE 4-1

indications, patient preferences, quality of life, and contextual features (Jonsen et al., 2006). Nurses and other healthcare professionals on the team gather information in an attempt to answer the questions in each of the four boxes.

The Four Topics Method promotes a dialogue among the patient, family, and members of the healthcare ethics team. Each patient's case is unique and should be considered as such, but the subject matter concerning the dilemma involves common threads among cases, such as withdrawing or withholding treatment and right to life. Applicability of the four fundamental bioethical principles—autonomy, beneficence, nonmaleficence, and justice—is considered along with data generated by using the Four Topics Method in analyzing a patient's case. In Table 4-1, each box includes principles appropriate for each of the four topics. The additional principles of fairness and loyalty are included in the contextual features section.

www CASE STUDY ■ MS. CRANFORD

You are a student nurse who is caring for Ms. Cranford. She is an 87-year-old mentally competent woman who has lived alone since her husband died 10 years ago. She was admitted to the hospital with chest pain, feeling faint, a pulse of 48, and a blood pressure of 98/56. The physician and nurses stabilized Ms. Cranford with medications and intravenous fluids but later informed Ms. Cranford and her only son that she would need a heart pacemaker to regulate her heartbeat. After the physician explained the procedure and risks involved, Ms. Cranford pondered the situation for a long while before discussing it with her son and the physician. Her medical history includes long-term adult-onset diabetes, chronic renal failure, and arterial insufficiency. She feels very tired. She decides that she does not want a pacemaker. Once Ms. Cranford tells her son her wishes, he is quite upset, and thus, he meets with the physician to discuss the options. The physician and Ms. Cranford's son revisited this issue with her in an attempt to persuade her to change her mind, but she continues to refuse the recommended treatment. She and her son argue. The physician tries to explain to Ms. Cranford that the pacemaker is for her benefit, in her “best interest,” and involves very minimal risks to her.

She feels as if they are “ganging up” on her. Once the registered nurse becomes aware of the problem, you and the nurse visit with Ms. Cranford and her son to assess and evaluate the ethical issues involved with her case.

Case Study Questions

Imagine that you are a nurse on the ethics committee consulted about Ms. Cranford's case. Answer the following questions:

1. What are the central ethical issues and questions in this case?
2. Which principles are in conflict in this case?
3. What did the physician mean by “best interest” for Ms. Cranford?
4. Use the Four Topics Method to discuss issues, to identify additional information that might be needed, and to analyze this case. What are your recommendations on behalf of the ethics committee?
5. What is the role of the nurses caring for Ms. Cranford in resolving this situation with the ethics team, her other healthcare providers, Ms. Cranford, and her son? ■

COMPETENCY BOX 4-4

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Professionalism:

Knowledge (K7) Understands ethical principles, values, concepts, and decision making that apply to nursing and patient care

Skills (S7b) Utilizes an ethical decision-making framework in clinical situations

Source: Massachusetts Department of Higher Education (2010, p. 14).

Intense emotional conflicts between healthcare professionals and the patient and family can occur and hurt feelings can result. Nurses need to be sensitive and open to the needs of patients and families, particularly during these times. As information is passed back and forth among healthcare professionals and patients and families, an attitude of respect is indispensable in keeping the lines of communication open. Nurses play an essential role in the decision-making process in bioethical cases because of their traditional roles as patient advocate, caregiver, and educator. Nurses must attempt to maximize the values and needs of patients and families. A key component in preserving patient autonomy, respect, and dignity is for the nurse to have all of the essential information necessary for wise and skillful decisions.

Conclusion

With any type of ethical matters in health care, a nurse must ask “What is good in terms of how one wants to be?” and “What is good in terms of what one ought to do?” Becoming ethically savvy does not just happen in nursing. Nurses must consciously cultivate ethical habits and use theoretical knowledge about how to navigate ethical dilemmas. Moral suffering cannot be eliminated from nursing practice; however, the cultivation of wisdom and skill in decision making can help to alleviate some of its effects.

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