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Ethical curriculum development and teaching

Mary Eunice McBean

ETHICAL CURRICULUM DEVELOPMENT AND TEACHING

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Science

in

Nursing

_____

by

Mary Eunice McBean, RN

December 2003

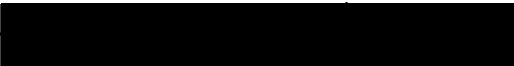ETHICAL CURRICULUM DEVELOPMENT AND TEACHING

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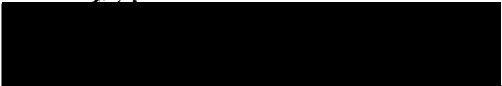Susan Lloyd, RN, Ph.D., Chair, Nursing   11-17-03
                                              Date

Ellen Daroszewski, RN, Ph.D.

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ABSTRACT

The purpose of this project was to develop an
ethical curriculum for use in clinical practice for the 5
Tower North Staff Nurses at St. Bernadine Medical Center.
The need for this curriculum was based on data from a
previous assessment completed with this same population
of nurses. It is hoped that this curriculum will help
increase their awareness of ethics, ethical dilemmas, and
will assist them in resolving ethical issues using
ethical theory and The Moral Decision-Making Model.
Teaching strategies for the curriculum focus on the use
of case studies to promote critical thinking and problem
resolutions.

ACKNOWLEDGMENTS

My sincere appreciation and profound gratitude, is extended to the chair and members of the committee for their unwavering and tireless efforts in making this project a reality. Very special thanks is extended to Mr. Craig La Force for his overwhelming support and guidance with computer technical skills, my sister Rose, who encouraged me to choose nursing as a career path, and my beloved son Michael, who encouraged me to study when I was exhausted. My deepest and sincere thanks is extended to Dan, Barbara and Louise, my dear friends and confidants who were always there when I needed a friend to lean on, confide in, and listen to my tales of woe. May God bless all of you!

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CHAPTER ONE

ETHICAL CURRICULUM DEVELOPMENT AND TEACHING

Introduction

While ethical quandaries and dilemmas are
commonplace for nurses, recent advances in technology
have and will continue to create new challenges and
controversies. Throughout time, nursing has been an
ethical endeavor, with nurses viewing the ethical
mandates of their responsibilities on a par with other
core dimensions of their professional life (Scanlon,
2000).

Unprecedented advances in science and technology
have tremendous promise for understanding disease and
promoting human health, yet at the same time they raise
complex ethical questions. The health care community must
anticipate and prepare for the poignant consequences and
problems associated with the vast scientific progress in
medicine and bioethics. Therefore, it is imperative that
nurses, together with other health care professionals, be
challenged to consider thoughtfully, to guide responsibly
and to ground reasonably the integration of ethics into

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the delivery of health care and thus keep the scale weighed on the side of promise on ethics (Scanlon, 2000).

Unfortunately, nurses out of school for several years may find themselves without the educational background to deal with the multitude of situations facing them in their daily practice. One way of assisting nurses to increase their knowledge base regarding ethics and ethical decision-making is through in-service educational programs (Cragg, 1988).

Problem Statement

Nurses must understand the basis on which they make ethical decisions. Ethical reasoning is the process of thinking through what one ought to do in an orderly and systematic manner to provide justification for their actions based on principles. Ethical decisions cannot be made in a scattered unorganized approach based on intuition or emotions. Ethical decision-making is a rational way of making decisions in nursing practice. Ethical decision-making models are used in situations in which the right decision is not clear or in which there are conflicting rights and duties (Beauchamp, 1994).

For example, with the recent advances in medical technologies such as stem cell replacement, cloning, internet purchasing of donor organs, and the Human Genome Project, the ethical decision-making of health care providers has been uniquely challenged (Hein, 2001). Health care providers and consumers are concerned with how decisions are being made, and asking the question, "Is this Ethical?" When viewed together with profound changes in family structures, such as social, economic, and provisions for health care, these challenges generate unprecedented ethical concerns (Hein, 2001).

Among those health care providers that are being challenged are the staff nurses at St. Bernardine Medical Center, on Five Tower North, who express concern in awareness, understanding, analyzing, and resolving ethical dilemmas that are unit specific. The introduction of ethical decision-making models and a proven ethical curriculum has been shown to provide guidance in these challenging times.

Purpose of the Project

The purpose of this project is to develop a curriculum, which will examine the ethical methods or

practices used by nurses in resolving ethical dilemmas in clinical practice utilizing the case study method for staff nurses at St. Bernardine Medical Center.

Scope of the Project

The scope of the project includes the following:

1. Analyze previous assessment findings related to staff nurse's ethical understanding of clinical decision-making.

2. Utilize decision-making models to develop an educational curriculum based on assessment findings.

3. Develop an evaluation tool for future use.

The project will address the issues of teaching nurses to recognize the ethical aspects of their professional practice, enabling them to examine and affirm their own personal and professional moral commitments.

This curriculum will help provide them with the ethical foundation necessary for the use of interaction skills needed to apply this insight and knowledge in resolving ethical dilemmas in clinical practice.

Significance Of The Project

All health care professionals have to face ethically problematic situations, and therefore may certainly benefit from education in the theory and practice of ethics. It is particularly important, however, that the nurses who face the most difficult decisions, receive adequate education and content-specific support and training (Nilstun et al, 2001).

When faced with ethical dilemmas, nurses need to feel able to address theses issues in an articulate and competent manner. Because they may have received limited formal education in their academic programs, nurses need ongoing in-service programs to increase their ability to deal with the complex situations they face on a daily basis in the practice setting (O'Neil, 1991).

Definition of Terms

Ethics - a body of principles or standards of human conduct that govern the behavior of individuals and groups (Catalano, 1995).

Veracity - a duty to tell the truth among human beings (Catalano, 1995).

Justice - the obligation to be fair to all people

(Catalano, 1995).

Morals - the fundamental standards of right and wrong

that an individual learns and internalizes

(Catalano, 1995).

Code of Ethics - a written list of a profession's values

and standards of conduct (Catalano, 1995).

Values - ideals or concepts that give meaning to the

individual's life (Catalano, 1995).

Ethical Dilemma - a situation that requires an individual

to make a choice between two equally unfavorable

alternatives (Catalano, 1995).

Explication - Clearly stated and leaving nothing implied

(Catalano, 1995).

An Ethical Code - a frame work for decision-making

(Catalano, 1995).

Deontological - a theory of ethical decision making based

on the discovery and confirmation of a set of morals

or rules that govern the resolution of ethical

dilemmas. Deontology attempts to determine what is

right or wrong based on one's duty or obligation to

act rather than on the action's consequences

(Catalano, 1995).

Nurture - The act or process of raising or promoting the development, training, educating, and fostering another (Catalano, 1995).

Paradigms - A pattern, example, or model, an overall concept accepted by most people in an intellectual community, as those in one of the natural sciences, because of its effectiveness in explaining a complex process, idea, or a set of data (Catalano, 1995).

Teleological - an ethical theory that derive norms or rules for conduct from the consequences of actions. This theory is often referred to as utilitarianism (Catalano, 1995).

Beneficence - an ethical principle that states that the actions one takes should promote good (Catalano, 1995).

Nonmaleficence – an ethical principle that states one should do no harm (Catalano, 1995).

Autonomy - addresses personal freedom and self-determination-the right to choose what will happen to one's own person (Catalano, 1995).

The Greatest Good Principle – a system of ethical decision-making which is based on utilitarianism (Catalano, 1995).

Principalism - an emerging ethical theory which attempts

   to incorporate various existing ethical principles,

   by which to resolve conflicts by applying one or

   more of these principles (Catalano, 1995).

                   Limitations of the Project

The project has the following limitations:

1.   Time constraints of the nurses, due to

      inadequate staffing ratios, high patient acuity

      and mandates imposed by management and union

      labor laws.

2.   Use of the curriculum will varying education

      levels of the Five Tower North nursing staff.

3.   Getting the nurses to participate in an

      educational program or project, which is not a

      mandatory process.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The literature review describes the importance of
ethical decision-making in health care.

Educational and Curriculum Decision-Making Models

Ethical Decision-Making

The importance of ethical decision-making in health
care nursing reminds us that there are no easy,
straightforward answers in ethics or ethical dilemmas.
According to (Guido, 2001) ethical theories form an
essential base of knowledge from which to proceed.

Without ethical theories, the decision resolves
solely on personal emotions and values. Because most
nurses do not ascribe to either the ethical principles of
deontology or teleology exclusively, but to a combination
of the two theories, Principalism, which is growing in
popularity.

Education and Curriculum Decision-Making Models are
two particular models that assist nurses to recognize
what a moral or ethical dilemma is. Educational Models in
ethical education should include issue identification,

basic ethical theory, issues analysis, and application of ethical principles in professional practice (Gilbert, as cited in O'Neil, 1991). Curriculum Models, according to Holland (1999) are useful in enhancing the quality of care nurses provide by enabling them to cope with the moral dimension of their profession, enhance understating of ethics, and raise awareness of the ethical demands placed on them by nursing. Curriculum models and curricula are continuously shrouded in definitional controversy, since the days of John Dewey's Democracy and Education in 1928, according to professor William Schubert, a college administrator at the University of Illinois in Chicago. Schubert suggests that a curriculum should advocate for teaching and learning and be specific for the learner. Instead, many curricula consists of the textbooks taught, the tests given, and the instructional decisions made by individual educators behind closed classroom doors, which fail to address the educational needs of the learner (Reed, Bergemann, & Olson, 1998). The curriculum model that is being developed for the Five Tower North staff nurses will avoid these pitfalls, due to an earlier needs assessment of what the nurses have previously recognized and identified as improvements in

their ethical knowledge. According to the literature, there has been an increasing recognition of the need to involve collaboration from all interested parties who has a vested interest in the process to become active participants. For the collaborative, collegial is evident when professionals work together for at least five ways, such as: teams can work together, professional discussion, curriculum development, peer observation/coaching, and research (Rosenholtz, 1989; Glatthorn, 1987).

The art and science of teaching imply a need to continually blend new information from educational research into daily practice through thoughtful evaluation of and reflection on daily experiences and choices in the classroom. Only by reviewing your actions in the classroom can you formulate better approaches for the future (Slavin, 1997).

Two popular models are:

(1)   The Parallel Distributed Processing Model

(2)   The Connectionist Model

The Parallel Distributed Processing Model introduced by Lewandowsky and Murdock in 1989, was described based on the idea that information is processed simultaneously

with different parts of the memory system operating on the same information at the same time. For example, when reading this paragraph, an individual is not looking at individual letters, forming them into words and meanings, and then working with them in short-term memory to file them in long-term memory. Instead, the individual immediately uses information in their long-term memory to interpret the words and meanings. Even at the first stages of perception what is seen is heavily influenced by what one expects to see. Which means that ones long-term memory is operating at the same time as ones sensory register and short-term memory (Slavin, 1997).

Connectionism

Rumilhart and McClellard introduced the Connectionism Model in 1986. They felt their model was closely associated with the Parallel Distributed Processing Model. This model emphasizes the idea that knowledge is stored in the brain in a network of connections, not in a system of rules or in storage of individual bits of information. Connectionist Models are appealing for several reasons. First, they are consistent with current research on the brain which has established that information is not held in any one location, but is

distributed in many location and connected by intricate

neutral pathways. Second, connectionism can be modeled

mathematically and simulated in computer-based artificial

intelligence experiments.

The implications of connectionism for teaching and

learning are not clear. A straightforward application

would recommend placing a greater emphasis on

experienced-based teaching and a de-emphasis on teaching

of rules, but researchers in this tradition are careful

to note that the Connectionist Model does have a place

for rule-based teaching. Development of connectionist

education is happening rapidly, and in the coming years

this model may replace the Parallel Distributed

Processing Model and give clear guidance to educators on

applications of connectionist principles (Slavin, 1997).

Ideally, Curriculum Decision Making-Models should be

involved in the process of developing a curriculum.

Although numerous models exist from which to choose, most

models can be classified as technical, non-technical, or

holistic. This type of classification represents our

current stage of curriculum knowledge development. Many

social and educational critics indicate that we are

leaving or have left the modern period, which stressed

the technical, the precise, the certain and have entered

into the postmodern period, which emphasizes the

non-technical, the emergent, and the uncertain. However,

our history in the modern or technical period is much

longer than our time in this new age, the postmodern.

Thus, we have more technical models upon which to

draw guidance in curriculum development. The newness of

this emergent time that we are experiencing is suggested

by the fact that we really do not know what to call it,

so we call it postmodern (Salvin, 1997).

Likewise, we are stymied in our attempt to be

original in naming our emerging processes of curriculum

development. We just classify them as non-technical. The

three most popular curriculum models include: The Tyler

Model, The Taba Model, and The Hunkins's Decision-Making

Model.

Without doubt, Tyler's is one of the best-known

technical-scientific models, in which he outlined a

rationale for examining the problems of curriculum and

instruction. He mentioned that those involved in

curriculum inquiry must try to define the 1) purposes of

the school, 2) educational experiences related to the

purposes, 3) organization of these experiences, and 4) evaluation of the purposes (Tyler, 1949).

By "purposes," Tyler was referring to objectives. He indicated that curriculum planners should identify these general objectives by gathering data from three sources: the subject matter, the learners, and the society. After identifying numerous general objectives, the curriculum planners were to refine them by filtering them through two screens, the philosophy of the school and the psychology of learning. What resulted from such screening were specific instructional objectives (Tyler, 1949).

Tyler then discussed how to select educational experiences that would allow the attainment of objectives. Learning experiences had to take into account both the previous experience and the perceptions that the learner brings to a situation. Also, the experiences were to be selected in light of what educators know about learning and human development.

Tyler next talked about the organization and sequencing of these experiences. He purported that the ordering of the experiences had to be somewhat systematic so as to produce a maximum cumulative effect. He thought that organizing elements, such as ideas, concepts,

values, and skills, should be woven as threads into the curriculum fabric. These key elements could serve as organizers and means and methods of instruction, and they could relate different learning experiences among different subjects (Tyler, 1949).

Among Tyler's colleagues was Hilda Taba, who was very influential in giving his approach to curriculum an added boost, and developed The Taba Model. In her book on curriculum development, *Curriculum Development Theory and Practice* (1962), she argued that there was a definite order to creating the curriculum. Pursuing such order would facilitate attaining a more thoughtful and dynamically conceived curriculum. Where Taba differed from Tyler was that she believed that those who teach the curriculum, the teachers and planners should participate in developing it. She advocated what has been called the grass-roots approach. Educators during the early days of curriculum making thought that the central authorities really had the knowledge for creating curricula. This was the top-down or what some have called the administrative or line-staff model. Ideas from curriculum experts were frequently given to teachers to develop, and then

administrators supervised the teachers to ensure that the ideas were implemented (Taba, 1962).

Taba felt that the administrative model was really in the wrong order. The curriculum should be designed by the users of the program. Teachers should begin the process by creating specific teaching-learning units for their students. She advocated that teachers take an inductive approach to curriculum development--starting with specifics and building to a general design--as opposed to the more traditional deductive approach--starting with the general design and working toward the specifics (Taba, 1962).

Taba noted seven major steps to her grass-roots model in which teachers would have major input:

1.   *Diagnosis of needs*. The teacher (curriculum designer) starts the process by identifying the needs of the students for whom the curriculum is to be planned.

2.   *Formulation of objectives*. After the teacher has identified needs that require attention, he or she specifies objectives to be accomplished.

3.   *Selection of content.* The objectives selected or created suggest the subject matter or

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content of the curriculum. Not only should objectives and content match, but also the validity and significance of the content chosen needs to be determined.

4. *Organization of content*. A teacher cannot just elect content, but must organize it in some type of sequence, taking into consideration the maturity of the learners, their academic achievement, and their interests.

5. *Selection of learning experiences*. Content must be presented to pupils and pupils must engage the content. At this point, the teacher selects instructional methods that will involve the students with the content.

6. *Organization of learning activities*. Just as content must be sequenced and organized, so must the learning activities. Often the sequence of the learning activities is determined by the content. But the teacher needs to keep in mind the particular students whom he or she will be teaching.

7. *Evaluation and means of evaluation*. The planner should decide what objectives have been

achieved. Evaluation procedures need to be considered by the students and teachers (Taba, 1962).

Curriculum Conceptualization and Legitimization

Ornstein and Hunkins (1998) presented a decision-making model of curriculum development that at first glance appears to be another technical-scientific example. It has seven major stages: curriculum conceptualization and legitimization; diagnosis; content selection; experience selection; implementation; evaluation; and maintenance.

What sets this model apart is its recommended first stage of curricular decision making: Curriculum conceptualization and legitimization. The first stage demands that participants engage in deliberation regarding the nature of curriculum and also its educational and social-political value. This first stage requires curriculum decision makers, whoever they may be, to engage in a search for an understanding of curriculum, as well as just creating educational programs. It addresses the concerns of reconceptualists, of putting stress on understanding the nature and power of curriculum (Ornstein & Hunkin's, 1998).

CHAPTER THREE

METHODOLOGY

Introduction

Competent health care delivery by Health Care

Professionals is expected throughout all of society.

However, defining what it is and teaching new learners

how to perform competently faces many challenges.

Increased competency in curriculum based-education has

become a common theme in contemporary society, where the

public good should be protected, relating to education

and teaching (Redman, Lenburg, & Walker, 1999).

In the past, such issues as patients' rights,

professional misconduct, and organ procurement was

covered during the orientation process or at the initial

time of employment. However, during random evaluations

for compliance, many employers were in violation

(Gilbert, 1986). In an effort to become compliant,

employers charged the hospital educators with the task of

development, implementation, and evaluation of required

in-service education. Their jobs were to create teaching

strategies that would facilitate learning at the

individual level, encourage staff participation at the

unit level, and contain cost at the departmental level

(Gilbert, 1986). Developing and implementing unit

specific education programs are becoming valuable tools

in meeting these regulatory compliances.

Methodology

At St. Bernardine Medical Center, in San Bernardino

California, the staff nurses on Five Tower North,

identified their educational needs, based on a previous

needs assessment, to be ethical dilemmas that they were

facing daily in their practice. Over a period of several

months, this aggregate group of registered nurses were

involved in several patient care related issues, that

caused them to question their actions and feelings. This

project is being done in an attempt to equip these

registered nurses with the knowledge they need and to be

able to effectively resolve some of their concerns. It is

the intent of this project, to develop a curriculum which

will provide a framework for identification,

understanding, working-through, and resolving ethical

dilemmas as they arise on the unit, focusing on ethical

decision-making models and the case study method.

The use of case studies as a research methodology has grown in recent years because of the rapid changes in the health system today and the inability of traditional data sources to answer important questions. Many users of case study information value the data, but are uncomfortable with the small number of cases included in any given study and the uncertainty associated with interpreting the data.

As more researchers pursue this methodology, it is important to recognize that numerous methodological strategies related to implementing such research can enhance the reliability and validity of the findings (Kohn, 1997).

The case study methodology is frequently applied in program evaluation studies or studies that track changes in complex systems. The nature of the problem and the theories of interest dictate the mix of methods used to answer any particular set of questions.

Researchers use case study methodology for the following purposes: 1) To explore new areas and issues where little theory is available or measurement is unclear; 2) to describe a process or the effects of an event or an intervention, especially when such events

affect many different parties; and 3) to explain a complex phenomenon.

This curriculum will be given to the education office at St. Bernardine Medical Center for implementation into their nursing in-service program.

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Nursing is a practice profession that integrates teaching in the clinical setting as an integral part of the total education process for nurses. The primary purpose of nurse educators in clinical practice is to provide teaching for novices and experts. The clinical setting is where validation of previously learned principles and concepts occurs and where the use of skills learned in simulated environments takes place. Ideal clinical experiences are those which are closely relevant and timely to what is being taught in concurrent courses and which allows continued reinforcement and practice of what has been learned. Unfortunately, not every institution has educators and staff nurses knowledgeable in the teaching of ethics or ethical concepts, which leaves nurses at a disadvantage. To reverse this process, the development of an ethical curriculum designed specifically with basic ethical concepts and ethical decision-making skills would help to resolve this dilemma.

Recommendations

For implementation of educational classes it would be helpful if the nurse educators would:

1. Become very familiar with all of the material in the teaching packet.

2. When using case studies, focus on the decision-making process rather than a straight right or wrong answer.

3. Encourage participant expressions of personal and morals and values.

4. Adapt the material as appropriate for the specific participant group, over 2-3 separate class periods.

APPENDIX A

EDUCATIONAL CURRICULUM

EDUCATIONAL CURRICULUM

Course Description

This course is designed to introduce the nurses on Five Tower North to the concepts of ethics, ethical dilemmas, and ethical decision-making models, case studies, resolving ethical dilemmas using the case study method. The subjects to be covered include unit case scenarios, ethical decision-making models, application of the models to the case scenarios and working through the case scenarios using The Moral Model. The definition of ethics, three ethical theories, ethical dilemmas, and the Nurses Code of Ethics will also be discussed.

Curriculum Objectives

By the completion of these classes, the nurse will be able to:

1.   Define ethics.

2.   Identify two ethical systems.

3.   Define ethical dilemma.

4.   Differentiate between a floor event and a case study.

5.   Discuss the steps in the Moral Model.

6.   Use the Moral Model to resolve an ethical dilemma.

CURRICULUM STRATEGIES

Combination Approach

A combination approach of packet in-service education and handouts can be made available to the nurses. Daily reminders of some of the ethical principles can be given to the nurses during A.M. and P.M. shift report. Reminders of meeting times should be posted on a regular basis.

The Fifteen-Minute Learning Break Method

This mechanism provides brief education opportunities to busy staff nurses in the clinical setting. It requires that each clinical unit have a bulletin board, communication book, or education folder to post a one or two page flyer. The nurse educator on a weekly or monthly basis prepares the flyer. Flyers contain content that can be read in fifteen minutes or less. The information included needs to be self-explanatory. Flyers may contain cited literature, an alert to change in a policy or practice, or original content developed by the educator. Each flyer will have a different theme, ie: (1) Self-Esteem Building, (2) Five Minute Facts, (3) Team-Building Ideas, and (4) Working with Difficult People.

Traditional Learning Method

One half hour lectures and group discussions will be available for the Five Tower nurses.

In-Service Education Poster

To familiarize nurses with ethical concepts, a large poster board can be formatted with some of the key concepts as cues one week in advance.

Also included on the board will be a list of ethical principles and definitions of ethical terms. The poster board should be located in the staff lounge.

APPENDIX B

ETHICAL DECISION-MAKING CURRICULUM

ETHICAL DECISION-MAKING CURRICULUM

Course Content Outline

Class #	Class Topics	Curriculum Strategies
Class #1	Introduction & Overview Class Objective: Code of Ethics	Lecture Handouts
Class #1	Ethical Principles/Theories (Deontology & Teleology)	Group Discussion Handouts
Class #2	Ethical Decision-Making	Lecture
Class #2	Use of the Moral Model	Group Discussion Group Work
Class #3	Use of the Moral Model	Lecture Group Work
Class #3	Ethical Dilemma Case Studies	Group Discussion Group Work

PROFESSIONAL ETHICAL CODES

Codes of ethics serve a variety of purposes. They serve as one basis for developing pre-service curricula for the particular professional group. They help to orient the new practitioner to their professional responsibilities, rights, and privileges. They furnish the basis for distinguishing scrupulous and unscrupulous conduct. They serve as a basis for regulating the relationship of the practitioner to consumers of the professional service, to the profession itself, to society, and co-workers within and outside the profession (Notter & Spalding, 1976).

A professional code of ethics provides a framework for making ethical decisions and sets forth professional expectations. Nursing codes of ethics inform both nurses and society of the primary goals and values of the profession. Reflected in the codes are universal moral principles such as respect for person; autonomy (self-determination); beneficence (doing good); nonmaleficence (avoiding harm); veracity (truth-telling); confidentiality (respecting privileged information); fidelity (keeping promises); and justice (treating people fairly). These principles should be compatible with the nurse's personal value system and moral code. The three most noteworthy Codes of Ethics for Nurses that have been identified by the international nursing community, that continually guide nurses in practice are:

(1)   American Nurses Association Ethical Code for Nurses

(2)   Canadian Nurses Association Code of Ethics for Nursing

(3)   International Council of Nurses Code of Ethics for Nurses (Taylor, Lillis, & LeMone, 1997).

The American Nurses Association Ethical Code for Nurses is a professional code of ethics that provides a framework for making ethical decisions and sets forth professional expectations. The codes of ethics inform both nurses and society of the primary goals and values of the profession. Reflected in the codes are universal moral principles such as respect for persons, autonomy (self-determination), beneficence (doing good), nonmaleficence (avoiding harm), veracity (truth-telling), fidelity (keeping promises), and justice (treating people fairly (ANA, 1985).

The American Nurses Association Ethical Code For Nurses with interpretive statements, provides direction for practice and for the fulfillment of ethical obligations. The explication of these ethical norms and values that shape professional practice is necessary as nurses confront the integration of ethical care into health care (Scanlon, 2000).

The body of the Canadian Nurses Association Code of Ethics For Nursing is divided into four categories that speaks to the obligations of the nurse. These categories include clients, nursing roles and relationships, nursing ethics and society, and the nursing profession.

The International Council of Nurses Code of Ethics For Nurses, was first adopted by the ICN at São Paulo, Brazil on July 19, 1953 and revised in Frankfort, Germany in 1965 and again in Mexico City in 1973. This International Code includes the following concepts: (1) Ethical Concepts Applied to Nursing, (2) Nurses and People, (3) Nurses and Practice, (4) The Nurse and Society, (5) Nurses and Co-Workers, and (6) Nurses and the Profession (Notter & Spalding, 1976).

The International Counsel of Nurses (ICN) Code of Ethics for Nurses and the rights and laws that guides practice when nurses are faced with any kind of ethical problem is a resourceful document that nurses should have an understanding of in their clinical practice.

According to O'Neil, (1991) nursing is becoming more and more technically complex, requiring increasingly complex moral decision-making. Considering that health care facilities are developing ethics committees and ethics rounds, nurses must increase their knowledge and articulation of underlying ethical concepts and decision-making processes in order to participate in this arena. To achieve this objective, development of an ethical curriculum to acquaint nurses with basic ethical concepts and bioethical decision-making skills, to resolve ethical dilemmas is the aim of this project. Much has been written to suggest that the process of teaching ethics in nursing education begins with moral development and values clarification components. Among these educators are Berkowitz, Frisch, Fry, Packard and Ferrara, Gilbert, Crisham, and Ketefian.

Berkowitz stated that the "goal of a nursing ethics education curriculum should be to nurture the development of higher forms of moral reasoning" (as cited in O'Neil, 1991, p. 184).

Gilbert suggested that ethical education in nursing also includes issue identification, basic ethical theory, issue analysis, and application in professional practice. Many nurses in practice today have had little formal education in that area, which may have been childhood religious classes where the purpose was to set moral values rather than teach the process of moral reasoning (as cited in O'Neil, 1991).

Crisham and Ketefian showed that nurses with a higher education level demonstrated higher levels of moral development and reasoning (as cited in O'Neil, 1991).

However, findings have also shown (Aroskar, 1986) said that nurses in the clinical setting do not always recognize what a moral dilemma is. Mayberry (1986) noted that nurses frequently use intuition rather than a critical inquiry process when faced with the need to solve ethical problems.

In addition, Cragg (1988) indicated the need to include ethics presentations in postgraduate continuing education programs. Thus, nursing education provides the forum for educating the nurse-learner in ethical concepts and the process of critical analysis both within the academic setting and within continuing education and staff development settings. Unfortunately, not every institution has staff knowledgeable in the teaching of ethical concepts.

Cragg, (1988) also states that, ideally, nurse-ethicists would be available for teaching and consulting purposes. If this is not possible, the classes could be organized by interested, knowledgeable staff using guest lectures from local universities to present the didactic component or nurse-members of ethics committees for factual input and support. Ornstein and Hunkins, (1998) beliefs are that, "The domain of curriculum development is not static. New procedures are being suggested for changing existing curricula that draw on postmodern ways of thinking and employ new paradigms of curricula thought. Successful education requires careful planning and without planning, confusion and conflict are likely to characterize curriculum activity. To avoid this, educators must develop specific curriculum development strategies, much needed thought should be given to goals, content, learning experiences, methods, materials and to use evaluations of ethical programs."

Given the main aims of a course in ethics for nurses and the limited effectiveness of formal moral theory, it seems inevitable that the mainstay of nursing ethics courses will continue to be case study material. The point of ethics education for nurses is to enhance the quality of care they provide by enabling them to cope with the moral dimension of their profession. Presumably, a course in ethics for nurses has two main aims: to enhance understanding and awareness of the ethical demands placed on them by nursing; and to equip them to respond well to such demands with sound moral judgment (Holland, 1999). Teaching by cases promotes judgment, however it is not the only method available. The literature identifies reflective practice, story telling, decision-making, models, small-groups, and problem-based learning, (Holland, 1999).

Health care professionals deal directly with the life and health of individuals, so they are more likely to encounter ethical problems. People entrust their lives and their naked bodies to the health professionals who are

responsible for their care and treatment and they want to be sure that their trust will not be abused. This belief and trust demands that health care professionals carry out their responsibilities without relying on their own personal beliefs and values and without discriminating for religion, race, sex, nationality, or political or social status.

In the past, nurses were expected to be obedient without question and did not participate in ethical decision-making. Because of this traditional view towards nursing, ethics was regarded as the science of conduct, and the ethics content of nursing courses focused on the duties and obligations of nurses. However, the growing complexity of our health care system requires increasing responsibility for ethical decision-making in nursing care. In their practice nurses can be confronted with issues related to initiating resuscitation, discontinuing life-saving treatment, or patients refusing treatment. They may also find themselves involved in research being conducted without informed consent or in situations where information is withheld from patients. Ethical decision-making requires guidance and knowledge of the theory of ethics, ethical principles and ethical practice. Without formal preparation, this process may be intuitive and based on a personal sense of ethical correct actions. Nurses need to be prepared by their basic education to develop ethical decision-making skills (Dinc & Gorgulu, 2002).

The teaching of ethics in nursing education has become increasingly important in recent years and in order to train nurses better to participate in ethical decision-making, more contemporary models of ethics teaching (e.g. moral concepts, clinical practice models, case analyses) are being implemented in nursing programs.

Cassels and Redman, in 1989 made some suggestions for improving the ethical decision-making skills of students. In short, their recommendations were to teach students the basic theories and principles of ethics, the International Council of Nurses (ICN) Code of Ethics for Nurses, and the rights and laws that guide practice when nurses are faced with any kind of ethical problem. In addition, Dinc and Gorgulu (2002) stated that evaluations of ethical choices should be made with each student.

APPENDIX C

ETHICAL PRINCIPLES

ETHICAL PRINCIPLES

In clinical practice, nurses seldom rely on a single ethical principle when caring for patients. Often, the ethical principles that nurse employ every day in practice settings come into conflict with each other. For example, envision the scenario of an elderly but independent patient who cherishes his independence. As a caregiver, one must balance the need to preserve this independence (autonomy) while discussing with his family alternative living situations (beneficence). One way to begin resolving such issues is through ethical decision-making frameworks (Guido, 2001).

Most nurses apply eight ethical principles in everyday clinical practice, some to a greater degree than others. These ethical principles help the nurse make sound decisions about what is acceptable and unacceptable in nursing practice. Even though the nurse's ethical principles are based on time-tested norms, they must be dynamic to meet today's changing needs. Like any other profession, nursing is expected to maintain high ethical standards and understand nurse-patient boundaries when providing care (Catalano, 1995). Due to the rapid advances in technology and science, particular in biology and medicine, have given rise to ethical dilemmas in health care. These dilemmas may find the nurse and the patient with different ethical systems that can involve critical points in a person's existence, such as birth and death of which there is no clear-cut solutions. In today's health care arena, nurses have been challenged to think about the issues, to clarify their own values and ethical systems, and to make the best possible choices about how to resolve ethical dilemmas, employing the eight ethical principles. These being: (1) autonomy, (2) beneficence, (3) veracity, (4) (Nonmaleficence), (5) fidelity, (6) paternalism, (7) justice, and (8) respect for others (Guido, 2001).

Nurses are confronted with ethical challenges wherever they practice in the turbulent world of health care. Responding to ethical questions and problems always requires a reasoned approach, through a structured ethical approach or a belief in an ethical theory or principle.

Ethical Theories

The two popular ethical theories are Deontology and Utilitarianism (Teleology). Deontology is a theory of ethical decision-making based on the discovery and confirmation of a set of moral or rules that govern the resolution of ethical dilemmas. Deontology attempts to determine what is right or wrong based on one's duty or obligation to act rather than on the action's consequences because it emphasizes duty to obligation to another person, deontology is the only acceptable theory for ethical decision-making in health care. Deontology is based on unchanging and absolute principles derived from universal values at the heart of all major religions. Its basic principle is to

ensure survival of the species by fulfilling one's duty or obligation to another person and to act not in accord with one's duty or obligation is wrong (Catalano, 1995).

Teleology (Utilitarianism) is a theory of ethical decision-making that determines right or wrong based on an action's consequences. Teleology is sometimes called Situation Ethics or Calculus Morality. The principle of utility is the basis for teleology. Utilitarianism is a teleology theory that judges acts based on their usefulness. Useful acts bring about good, and useless acts bring about harm. Teleology has no strict principles, moral codes, duties, or rules to determine conduct in particular situations. A basic assumption of theology is that good and harm can be quantified, as in a mathematical formula, so that one can evaluate the degree of good and evil in a specific case. The decision maker judges actions of their consequences for the general welfare if all people acted in a similar manner in the same situation. In teleology, good is defined as happiness or pleasure. Right is defined as the greatest good for the greatest number of people (Catalano, 1995).

APPENDIX D

ETHICAL DECISION-MAKING MODELS

Ethical Decision-Making Models

The five most commonly used decision-making models in health care are: (1) The Golden Rule Model, (2) Kant's Absolute Duty-Based Model, (3) The Joseph Institute Model, (4) Ethical Mapping Model, and finally (5) The Moral Model. For the purpose of this project, the moral model will be the primary focus. Each of these five models has contributed a great deal of structure and attention regarding ethics and ethical dilemmas to the nursing profession, as well as other professions. The Golden Rule Model states that all decisions must take into account and reflect a concern for the interests and well being of all stakeholders. This rule suggests that you do unto others, as you would have them do unto you. However, this is not always easy. Different stakeholders can be affected by the decision in either a beneficial or detrimental way, and the Golden Rule does not tell how to make a choice that is best for everyone. We can demonstrate equal love or caring to every person affected by our decisions. Therefore, we must prioritize certain interests over others and advance the well being of people, even at the cost to others. Do the right thing. Ethical values and principles always take precedent over unethical ones. People's choices are not always clearly definable in terms of ethical and unethical. They may sometimes have a conflict that they see arising form the clash between what is ethics and ethical dilemmas (Josephson Ethics Institute, 2003).

Kant's Absolute Duty-Based Model suggests that the moral character of an action is determined by the principle upon which it is based-not upon the consequences it produces. The foundation of morality is the ability to be rationally. A rational being is free to act out of principle and to refrain from acting out of impulse or the desire for pleasure. Kant contends ethical obligations are higher truths, which must be obeyed regardless of the consequences and in spite of social conventions and natural inclinations to the contrary. This particular moral principle, is also referred to as Deontological Kant's Model of Ethics, is duty-based. Thus, people have an absolute duty to do the right thing under all circumstances, and what is right has nothing to do with the actual consequences produced or avoided. No exceptions, no excuses. According to Kant, moral obligations absolute, invariable and do not allow for exceptions or extenuating circumstances. One difficulty with Kant's principles is that their application is sometimes impractical, in the sense that it is contrary to someone's inclination. The unswerving application of rigid principles is a contradiction of what it means to practice ethics, especially in situations in which flexibility and adaptability are required (Bandman & Bandman, 2002).

The Josephson Model proposes that making good decisions is about choosing options according to ethical principles. Everything we say and do

makes a difference. It can start a chain reaction that affects the actions and decisions of hundreds of others in similar situations. Everything you say sends a message. In 90% of the ethical problems you face, most people know what they should do. The real question is weather you are willing to do the right thing when it is likely to cost more than you want to pay. Good decisions are both effective and ethical. Effective decisions accomplish intended goals efficiently. Ethical decisions demonstrate a commitment to do the right thing in the context of the Six Pillars of Character: trustworthiness, respect, responsibility, fairness, caring and citizenship (Josephson Ethics Institute, 2003).

Each day, nurse practitioners are faced with clinical situations and dilemmas that have no obvious right answers. One model used in research is ethical mapping. The process of ethical mapping as a reflective device is one such model that enables practitioners to reflect on dilemmas of practice in order to learn through the experience and inform future practice. Ethical mapping is illustrated around a single experience that an intensive care practitioner shared in an on-going guided reflection relationship. Within this process the practitioner draws on ethical principles to inform the particular situation, notably autonomy, doing no harm, truth telling and advocacy. Through reflection, ethical principles are transcended and assimilated into knowing in practice, enabling the practitioner to become more ethically sensitive in responding to future situations (Christopher, 1999).

MORAL CONDUCT AND THE MORAL MODEL

Moral conduct is described as a mood arousing good behavior with others by showing a happy medium, nice wording, and kind manners. The minimal limits of moral conduct are to be modest, speak honorably, and meet your brother cheerfully.

One of the expectations of moral conduct that every judicious individual exerts efforts for achieving is to have and attractive personality. It is surely a noble aim that cannot be attained by everyone except the virtuous and those who are characterized by knowledge ability, liberality, courage, and the like good traits.

All virtues, however, cannot be true matters of admiration unless they are connected to moral conduct. On that account, moral conduct is the core and pivot of virtues, and therefore used in a variety of instructive methods in favor of glorifying the moral conduct of an individual, such as follows:

"The best of you are the most well-mannered and generous ones who go on intimate terms with people and people go on intimate term with you, and whose places of residence are frequently trodden on by guests" (Guido, 2001).

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"He who has a good nature will have the reward of those who observe fasting in days and keep awake praying at nights" (Guido, 2001).

"You cannot treat people by means of your wealth; hence, you should treat them by means of your moral conduct" (Guido, 2001). The Moral Model follows this concept:

In explanation of the lettering of which the Moral Model was built upon, the letter "M" means collecting data that identifies the dilemma, recognizing that most problems have more than one component, such as the cultural, economic, and political contextual factors that are present. Identify the facts relevant to the ethical decision, such as the laws, professional ethical codes, and government regulations that enter into ones choices. Identify who is responsible for making the decision (i.e. who's decision is it to make?), in consideration of who has important stakes in the decision, as well as, all claimants potentially affected by the decision, both the majority and the minority. In addition, consider the opinions of the major players as well as their value systems, in attempt to see from the other's perspective.

The letter "O" means to clarify the options available and the consequences of each potential action, thus ushering in a higher level of understanding of the dilemma.

"R" represents the stage of determining and resolving. At this point we must determine the best/worst case scenarios of choosing each particular alternative, evaluating from the various moral perspectives of beneficence, autonomy, and justice. Such as, which option will produce the most good and do the least harm? (beneficence) Which option respects the rights and dignity of all stakeholders? (autonomy) And, which option promotes the common good? (justice) We must answer the questions honestly while considering all sides of the issue, and whether any rules or principles (legal, professional, organizational, or other) automatically invalidate a particular alternative? Constructing a list of options in a graph format can be instrumental in helping to clarify alternatives and outcomes. Positive options would be indicated with a (+) and negative options with a (-).

The letter "A" represents the affirmation and act position. Based on the previous review, now is the time to determine which of the options is best suited for action. Use the ANA Code for Nurses to support conclusions. Use a specific exercise to help check your decision and confirm your thinking. Consider if you told someone you respect about why you chose this option, what would that person say? Or, write a letter defending your decision to the party who potentially has the most to lose. Another excellent ploy would be to write a letter to your most serious detractor explaining why you've made the

decision you've made. After receiving the necessary feedback, decide on the appropriate action and develop a plan to achieve this action.

And lastly, the letter "L" is for looking back, evaluating the success of your intervention. Questioning whether personal/professional values where considered? Were ethical principles applied? How did the process turn out for all involved? If it had to be done over, are there things that you would have done differently (Guido, 2001)?

The Moral Model

"M" Massage the dilemma. Identify and describe the issues in the dilemma. Consider the options of all major players in the dilemma, as well as, value systems. This includes clients, family members, nurses, doctors, clergy, and any other inter-disciplinary health care members.

"O" Outline the choices. Examine all of the choices, including those less realistic and conflicting.
This stage is designed only for considering choices and not for making a final decision.

"R" Resolve the dilemma. Review the issues and choices, applying the basic ethical principles to each choice. Make a decision and select the best choice based on the view of all those concerned in the dilemma.

"A" Act by applying the selected choice. This requires actual implementation; the previous steps had allowed for only dialogue and discussion.

"L" Look back and evaluate the entire process, including the implementation. No process is complete without a thorough evaluation to ensure that those involved can follow through. If not, a second decision may be required and the process must start again at the initial step (Guido, 2001).

APPENDIX E

ETHICAL CASE STUDIES

ETHICAL CASE STUDIES

Case Study One: Refusal of an AIDS Patient

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing.* Philadelphia: A. Davis Company.)

Alice, RN, started working in home health care about (5) five years ago after she'd worked as a Staff Nurse on a busy Oncology unit for almost (7) seven years at a Local Trauma Center in a community hospital. Alice was a hard-working individual and a very responsible and reliable nurse with excellent assessment and nursing skills. She communicated well with patients and provided a high level of care to the patients she was assigned. Alice had an excellent reputation as being competent and hard working, although, she was inflexible when it came to the interpretation of protocols, procedures, and standing orders. Her approach was a "by-the-book" philosophy and was an essential part of Alice's psychological makeup and intertwined with all aspects of her life including her religious beliefs and value system.

A new patient had been referred to the agency for home care, which was a 40-year-old homosexual male who was HIV positive and in the terminal stages of Acquired Immunodeficiency Syndrome (AIDS). He and his parents decided that he would spend his last days at home rather than in a hospital intensive care unit (ICU). They resided in a rural location of the city, which made his referral a first case of AIDS for the agency.

The agency director gave Alice the referral and her scheduled visit date and time. After reviewing the referral form, she raced into the director's office, and shouted: "I will not take care of a patient who has AIDS. My faith proclaims that homosexuality is a sin against God and AIDS is a punishment for that sin!"

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a) What is the important data in relation to this situation?

(b) What is the ethical dilemma? State it in a clear, simple statement.

(c) What are the choices of action, and how do they relate to specific ethical principles?

(d) What are the consequences of these actions?

(e)   What decision can be made?

Other factors to consider:

(f)   Are there ever any situations when a nurse can ethically (and legally) refuse a work assignment?

(g)   What effect will the final decision have on the other staff members?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Two: Vickie's Narcotic Shortages

Patricia, an intern-permitte, had just finished her six-week probation on the 3 to 11 shift in a busy labor and delivery unit. Patricia was excited about her first job and developing new skills. The nurses on the unit embraced her without reservations and the camaraderie she felt with the other nurses helped to alleviate some of her anxiety.

Patients in the labor and delivery room were in constant pain and required frequent dosages in pain medications. At the end of the shift, the narcotics count was often incorrect. Patricia was being trained to do off-going shift count and noticed many discrepancies.

Patricia noticed that the narcotic count was always wrong when Linda, a veteran RN, was on duty. Patricia also noticed that Linda signed out pain medications for her patients at the 'minimal intervals' ordered all through the shift, even if the patient had not received any medication for the previous twenty-four hours.

Patricia discussed her suspicions with another nurse on the unit, who stated that Linda was an excellent nurse and too valuable to be replaced. Being a new nurse caused Patricia more anxiety when discussing the discrepancies with her co-workers. The nurse suggested that Patricia mind her own business and keep quiet.

Patricia recognized the symptoms of drug abuse after observing Linda more closely over a period of time. Linda's behavior was erratic with large mood swings, frequent absences, forgetting to give scheduled medication on time, and frequent and prolonged "bathroom" breaks throughout her shift. Patricia felt obligated to report Linda's behavior to an authority because she was a danger to herself and others.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a)   What should Patricia do?

(b)   What are the key elements in this ethical dilemma?

(c)   What does the Code of Ethics for Nurses say about incompetent practitioners?

(d)   Are there any legal and/or ethical obligations that apply to Patricia's actions?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Three: Pain Management Dilemma

Paul was admitted into the hospital due to excruciating uncontrollable pain. At 6 foot and 150 pounds, he was in a very weakened state, which rendered him unable to walk and care for himself any longer. He'd been diagnosed months ago with cancer that had already started to spread to other organs such as his lungs, liver and bones. Having received chemotherapy and his condition not seeming to be improving, coupled with the extensive dosages of narcotic medications that were having little to no effect on his pain, his doctor had to devise an alternate treatment plan.

It was determined, further chemotherapy would be unwarranted. Keeping Paul comfortable and as pain free as possible became first and foremost. A continuous morphine sulfate IV drip was started to help control the pain. Although he was able to communicate, as Paul's cancer spread, he contested loudly to his nurses when they had to move him in any way. His being underweight and very bony, his rapid deterioration was very evident. As required all patients unable to sit or stand, must be moved or turned on a very regular basis. The nurses that were responsible for Paul's care, consulted with one another to try and come up with a solution to this problem. They knew that they could not adhere to Paul's wishes to stop turning him, which would be putting him at risk for other complications such as infections and possibly sepsis. This was a major factor because an infection or sepsis would most likely be fatal at this stage of the disease, with no probable means of prolonging his quality of life. Veteran RN, Joan disagreed with the other nurses. She felt they were causing this terminally ill individual unnecessary extreme pain and that continuing to turn him was an insensitive act and in violation of his right to expire with dignity. She announced that she would not assist any longer in Paul's care as long as the process remained the same.

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Elizabeth, RN, stated that they should further consult with Paul, and let him have some input in the final decision. Brenda, RN, insinuated that they all should follow the attending doctors written orders and to leave it at that. That alternative was most unacceptable among the other nurses, because they felt that the staff nurse was the responsible party for patient's comfort and routine care.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a)   What should they decide? Violation of a standard of care can leave a nurse open to a lawsuit.

(b)   What about the patient's right to make a decision when this violates a standard of care?

(c)   Are there ever any situations where a nurse might legally and ethically violate a standard of care?

(d)   What are the consequences?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Four: Principles Of Legality

Phil was a 76 year-old, retired General from United States Armed Services. He lived alone in a small apartment in a rural community, and had to be admitted to a surgical unit of the town's hospital. After establishing his diagnoses of signs of weakness, dehydration, electrolyte imbalance, and malnutrition, the doctor was informed by Phil's neighbor, who had accompanied him to the hospital, that he apparently had a preoccupation with constant bowel movements because she'd witnessed him frequently taking mass quantities of various laxatives.

Even though he denied taking any drug store medications, he was observed as being slightly disoriented and was started on an IV electrolyte and fluid replacement therapy. The intake physician also ordered a high-calorie diet and complete bed rest. Although Phil was very cooperative and accepted his treatment without complaint, his frequent bathroom trips were being observed by is primary care nurse Betty.

Betty noticed that he was concealing something and trying to return a small bottle of laxative pills to his bedside table drawer, where he kept his leather bag of personal hygiene items. Nurse Betty questioned him on the

spot, only to receive his harsh reply, "What's it to you, I'm minding my own business, why don't you?" Betty, reported the incident to the attending physician, who then wrote an order to confiscate the case and investigate its contents.

The doctor made it very clear nurse Betty that it was imperative that he be informed if Phil was secretly still taking laxatives along with his prescribed treatments, because the prolonged and continued use of the laxatives would render his treatments void and senseless, because his condition would never improve. Being in total agreement with the doctor, nurse Betty agreed to do his biding. However, after spending a few moments in contemplation of executing such a task, she began to recall and question the basic principles of law and the legalities of violating a patients rights of privacy by inquiring into their personal affects without permission.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a)   What should she do?

(b)   What laws or ethical principles is she violating by searching this patient's belongings without permission?

(c)   Does the principle of beneficence ever excuse breaking the law?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Five: Physicians Authority

A delivery serviceman found John, 69 years old widower, confused, with multiple black and blue areas all over his body and a fractured femur, at his home. He was unresponsive when he arrived at the hospital, therefore his medical history and any present illness could not be obtained. He appeared as if someone had attacked him inside of his home, but this could not be verified, because he had no known living relatives. After being hooked up to a cardiac monitor in ICU for approximately 3 hrs, his condition took a severe turn. His cardiac rhythm showed complete heart block associated with ventricular systole. He was diagnosed Stokes-Adams syndrome, which gave the nature of his initial injuries some validity. With periodic relapses of disorientation and combative behavior, he slowly became more responsive.

John's primary physician and the cardiologist made the final decision to fit him with a permanent pacemaker, which was standard procedure in such cases.

After a briefing on the diagnoses, disease process and surgical procedures by the cardiologist, John was all ready for his surgery, excluding the signing of the pre op consent. The cardiologist wrote an order for the nurse that was in charge of Johns care, to have John sign. When she brought the consent to his room she questioned him about his understanding of his surgical procedure.

This patient teaching seemed to have caused more confusion and he became fearful and hostile. She continued in her explanations concerning the risks and benefits of receiving the pacemaker, until he stopped her stating that "he no longer had any intentions of getting such a awful thing put inside of his body, and that she could forget about him signing any paper at all.

After hearing from the nurse the reasons why John was now refusing to sign the consent forms, this infuriated the cardiologist. He was adamant about "her getting those forms signed no-matter what," and was very persistent in his belief that the patient had been unnecessary confused by her additional questioning, which he felt was an undermining of his authority as well.

Directions: Using the Moral Decision-Making Model, answer the following
questions:

    (a)   What are the ethical issues involved in this case study?

    (b)   Was the nurse "wrong" in teaching this patient?

    (c)   What should the nurse do at this point?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Six: Shortage Of Nursing Staff

In a very active surgical unit of a major community hospital, RN's, Cathy and Joan had been the care nurses for quite a few seriously ill postoperative patients. They both were working a great amount of overtime, due to the high count of recent admittances into their unit, the severity of their patients conditions, but most of all because of the daily "call off's" of most of the other nurses on their unit that had been attacked by a vicious virus that was circulating through the hospital, leaving nurses Cathy and Joan to carry the bulk of the extra workload.

As one might expect, the inevitable occurred, while performing their charting duties, they confided in one another that they'd both been feeling the effects of this respiratory virus that had affected their colleges and questioned

each other as to what they should do. They had been told earlier that three additional postoperative patients were to be admitted to their unit some time during the day and neither of them wanted to be a contributor to the nurse shortage that they'd already been experiencing. Realizing that they both should probably go home so they wouldn't be causing more harm to the patients by communicating their illness to individuals who were highly susceptible to infections, however they finally opted to take some over the counter flu medications and remained at work, very aware that the flu medications which contained antihistamines could possibly affect their professional judgment and their performances of some the more complicated duties.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a) What is the ethical dilemma in this situation?

(b) Did the nurses make the right decision in staying at work?

(c) What ethical principles are involved in making this type of decision?

(d) Could an "I was sick and taking medication" defense be used if either of them had made a serious mistake in patient care?

(e) What if a patient became ill with the viral infections the nurses had?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Seven: Dosage Dilemma

An 81 year old white male, Jeff was admitted to the medical unit with a diagnosis of metastasis cancer of the gallbladder. He had completed (7) seven treatments of chemotherapy and (5) five courses of radiation (9) nine months earlier with only temporary remissions of the disease. His condition had deteriorated rapidly during the last month, and his family was no longer able to care for him at home. His attending physician ordered morphine sulfate (MS) 5 mg IV to be given every two hours around the clock.

Although this was a relatively large dose of a strong narcotic medication to be given this frequently, Jeff tolerated the treatment for the first (24) twenty-four hours and reported a significant reduction in his pain. On the second morning after his admission, Jeff was difficult to arouse for his morning

vital signs and breakfast. When his nurse, Mary M., RN, finally did get Jeff awake, he was confused; his blood pressure was 70/40 with shallow respirations at (9) nine per minute. He still complained of severe generalized body pain and asked for "more of that medication that helped so much the day before."

Mary did not give Jeff his scheduled 7 a.m. dose of MS. She phoned the doctor and reported her assessment of the patient, expressing her belief that continuing the medication at the previously prescribed dose and frequency would be harmful to his patient. The doctor who had been busy with an emergency patient, stated - "Give the medication like I ordered it and, don't bother me with nonsense! - I'll see the patient during my rounds!" And slammed down the phone.

Directions: Using the Moral Decision-Making Model, answer the following questions:

    (a)   What should Mary do?

    (b)   If she continues to give the medication at the prescribed dose and frequency and the patient dies, could she be held liable for an intentional tort?

    (c)   What are the ethical principles involved in this case?

    (d)   How could she best resolve the dilemma?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Eight: Medication Order Mistake

Donald 55 year old, was admitted to the progressive care unit (PCU) with severe chest pain and a diagnosis of an acute anterior myocardial infarction (MI). After (3) three hours in the unit, he began to have short runs (ten to fifteen beats) of Ventricular Tachycardia (VT) that ended without treatment. The physician was called, and an order for lidocaine was obtained.

Kathy who was Donald's nurse, took the phone order for the medication. When obtaining the order, she mistakenly wrote down "1000 mg IV bolus, followed by drip at 2 mg per minute," rather than "100 mg IV bolus, followed by drip at 2 mg per minute." Alice, another RN who had been pulled to the PCU from the pediatric unit, offered to give the medication because Kathy was so busy. Alice gave the medication as the order was written, and Donald promptly went into cardiac arrest. Resuscitative measures, including a

pacemaker, proved futile in reviving him. It was only after the code was over and Kathy was completing her chart that she realized her error in writing down a dose that was 10 times more than the usual dose. The pediatric nurse was unfamiliar with the PCU medications and had given the wrong dosage. The patient had arrested so quickly after the medication was given that Alice had already gone back to the pediatric unit and did not even realize she had given a wrong dosage of the lethal medication. About that time, Donald's wife arrived on the unit to obtain his signature on some legal documents. She stopped at the desk where Kathy was completing her chart to thank Kathy for her care of her husband. Kathy feels very guilty about the incident and wonders if she should tell Donald's wife what really happened.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a)   What should Kathy do?

(b)   What would be the consequences of the possible choices of action?

(c)   What ethical principle(s) should underlie Kathy's decision?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Nine: Overcrowded Neurological Unit

Margaret, RN and head nurse of a busy urology unit, was reviewing the weekend staffing for the unit on a Friday afternoon. The unit's nine beds were full with patients in various levels of recovery from different surgeries. The staffing on the weekend was "short," with barely enough staff to safely care for current patients. After spending a great deal of time reworking the schedule, calling nurses on the phone, and trading days off, Margaret finally managed to arrange sufficient coverage for the unit.

As Margaret was closing her office for the weekend, Dr. North, a urologist, approached her and related the following situation. Ms. Phoenix, a 53-year-old patient with a bladder tumor, had been scheduled for surgery three days earlier. Because she had a very rare blood type that was difficult to match, the surgery had been delayed. The blood bank had just obtained the necessary units for the surgery and had informed Dr. North that he could now operate. Dr. North was wondering if the urology unit would be able to adequately care for Ms. Phoenix over the weekend.

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This was the only unit in the hospital equipped to provide appropriate nursing care for this type of patient, because Ms. Phoenix would most likely require one-to-one care for eighteen to twenty-four hours after surgery.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a)   Should Margaret tell Dr. North that he can go ahead with the surgery and that she will make the adjustments to provide care for this patient?

(b)   What ethical obligation does Margaret have to the patient?

(c)   How about her obligations to Dr. North and the hospital?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

Case Study Ten: Two-Day Charting Delay

It was an extremely busy 3 to 11 p.m. shift on the surgical unit of a large city hospital. Because it was a Monday evening, the unit was not only receiving fresh postoperative patients from surgery but was also in the process of discharging patients and admitting new patients for the next day's surgery schedule.

Millie, RN, charge nurse for the 3 to 11 shift, had worked on the surgical unit for (3) three years. She had a reputation as being a well-organized, competent, and hard-working nurse who seemed to be able to bring order out of chaos. On this particular shift, even her considerable skills in organization were failing to settle the unit to a point where she felt in control.

Ms. Sunday James, a 54-year-old diabetic, was being admitted at 3:00 P.M. to the surgical unit because of poor circulation in her legs and possible infection of her left foot. One of her admission orders was to culture the drainage from the sore on her great left toe. In checking the orders after the unit secretary had noted them, Millie decided to do the culture herself because the staff was already tied up in other activities. She explained the procedure to Ms. James and then proceeded to culture a draining sore on her "right" toe. The unit secretary took the culture to the lab with the appropriate slips.

During dinner, a patient aspirated and coded. Later that evening, a patient fell while attempting to climb out of bed with the bed rails up. It was almost 12:00 P.M. when Millie finally got to sit down and do her charting. After

all that had happened that evening, she was having some trouble remembering what she had done earlier in the shift.

When she came to Ms. James's chart, she remembered that she had gotten a culture and checked back on the orders to make sure it was actually ordered. The order said "C & S left great toe," so Millie charted, "1630 - Culture of right great toe obtained and sent to lab. Procedure explained to patient." And signed it.

On her way home that night, Millie was thinking about how busy the shift was and all that had happened. She wondered if she had done everything that was supposed to be done, and charted everything that needed to be charted. She also began thinking about Ms. James and the culture. By the time she reached home, she felt pretty sure that she had cultured the wrong toe. She would correct the chart in (3) three days when she was to return to work.

When Millie returned after her (3) three days off, she discovered that Ms. James had had a below-the-knee amputation of her right leg. The physician had decided to do the amputation because the culture that was sent to the lab had grown clostridium perfringens (gas gangrene). Millie felt that she was responsible for this mistake.

Directions: Using the Moral Decision-Making Model, answer the following questions:

(a) What should she do?

(b) If she "tells" or tries to correct the chart, could she be open to a lawsuit?

Adapted from (Aiken, T. D., & Catalano, J. T. (1994). *Legal, Ethical, and Political Issues in Nursing*. Philadelphia: A. Davis Company.)

APPENDIX F

COURSE EVALUATION FORM/APPROVAL

October 22, 2003

St. Bernardine Medical Center
2101 No. Waterman Avenue
San Bernardino, CA 92404

To: Roz Nolan
    Director of Education

From: Mary E. McBean
      Graduate Student

Dear Ms. Nolan:

Please accept this letter as a formal request from your office to use the Course Evaluation Sheet in my Thesis, "Ethics in Clinical Practice."

I have drafted this document, in order to expedite this process. A signature from you, at the bottom of this page, will signify your permission granted.

I am fast approaching the final deadline for this project along with all required documentation.

Thank you, for you prompt attention in this most urgent matter.

Sincerely,

Mary E. McBean

Signed: _____   Date: 10/22/03
Roz Nolan, Director of Education

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COURSE EVALUATION

PROGRAM TITLE_____ DATE_____

Please fill in your responses to evaluate this class, course, or presentation.

SCORING GUIDELINE:

1 = Exceeded Expectations   2 = Met Expectations   3 = Did Not Meet Expectations   N/A = Not Applicable

CONTENT

	1	2	3	N/A
1. The content was accurate and informative to you.	1	2	3	N/A
2. The content was presented in an organized manner.	1	2	3	N/A
3. The content was valuable and helpful to you.	1	2	3	N/A
4. Speaker(s) were knowledgeable and responsive to questions.	1	2	3	N/A

PROGRAM

	1	2	3	N/A
5. The length was appropriate.	1	2	3	N/A
6. The pace was appropriate.	1	2	3	N/A
7. Program integrated theory and work application.	1	2	3	N/A
8. Handouts and materials were conducive to learning.	1	2	3	N/A

SETTING

	1	2	3	N/A
9. Room was conducive to learning.	1	2	3	N/A

AUDIO-VISUAL SUPPORT

	1	2	3	N/A
10. Audio-visual materials enhanced presentation.	1	2	3	N/A

OVERALL SCORE:

1	2	3
(Exceeded)	(Met)	(Didn't Meet)

ADDITIONAL COMMENTS:

What is one thing that you learned that will be most helpful to you?_____
_____

What is one thing that was least helpful to you?_____
_____

Other comments or suggestions:_____
_____

Thank you!   Your feedback helps to improve future programs.

COURSE EVALUATION

PROGRAM TITLE _____   DATE _____

Please fill in your responses to evaluate this class, course, or presentation.

SCORING GUIDELINES:

1 = <u>Exceeded</u> Expectations   2 = <u>Met</u> Expectations   3 = Did <u>Not</u> Met Expectations   4 = Not Applicable

CONTENT

1. The content was accurate and informative to you.	1	2	3	N/A
2. The content was presented in an organized manner.	1	2	3	N/A
3. The content was valuable and helpful to you	1	2	3	N/A
4. Speaker(s) were knowledgeable and responsive to questions.	1	2	3	N/A

PROGRAM

5. The length was appropriate.	1	2	3	N/A
6. The pace was appropriate.	1	2	3	N/A
7. Program integrated theory and work application.	1	2	3	N/A
8. Handouts and material were conducive to learning	1	2	3	N/A

SETTING

9. Room was conducive to learning	1	2	3	N/A

AUDIO-VISUAL SUPPORT

10. Audio-visual material enhanced presentation	1	2	3	N/A
OVERALL SCORE	1	2	3	

ADDITIONAL COMMENTS

APPENDIX G

AMERICAN NURSES ASSOCIATION CODE OF ETHICS

FOR REGISTERED NURSES

Nursesbooks.org, the publishing program of ANA, grants you a one-time
only permission to reprint the Code of Ethics for Nurses to include as
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American Nurses Association Code of Ethics

Provision 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.

1.1 Respect for human dignity - A fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual. Nurses take into account the needs and values of all persons in all professional relationships.

1.2 Relationships to patients - The need for health care is universal, transcending all individual differences. The nurse establishes relationships and delivers nursing services with respect for human needs and values, and without prejudice. An individual's lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient. Such consideration does not suggest that the nurse necessarily agrees with or condones certain individual choices, but that the nurse respects the patient as a person.

1.3 The nature of health problems -The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by disease, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying.

The measures nurses take to care for the patient enable the patient to live with as much physical, emotional, social, and spiritual well-being as possible. Nursing care aims to maximize the values that the patient has treasured in life and extends supportive care to the family and significant others. Nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care. This is particularly vital in the care of patients and their families at the end of life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying.

Nurses are leaders and vigilant advocates for the delivery of dignified and humane care. Nurses actively participate in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and patient suffering. The acceptability and importance of carefully considered decisions regarding resuscitation status, withholding and withdrawing life-sustaining therapies, forgoing medically provided nutrition and hydration, aggressive pain and symptom management and advance directives are increasingly evident. The nurse should provide interventions to relieve pain and other symptoms in the dying patient even when those interventions entail risks of hastening death. However, nurses may not act with the sole intent of ending a patient's life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations. Nurses have invaluable experience, knowledge, and insight into care at the end of life and should be actively involved in related research, education, practice, and policy development.

1.4 The right to self-determination - Respect for human dignity requires the recognition of specific patient rights, particularly, the right of self-determination. Self-

determination, also known as autonomy, is the philosophical basis for informed consent in health care. Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment; to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or penalty; and to be given necessary support throughout the decision-making and treatment process. Such support would include the opportunity to make decisions with family and significant others and the provision of advice and support from knowledgeable nurses and other health professionals. Patients should be involved in planning their own health care to the extent they are able and choose to participate.

Each nurse has an obligation to be knowledgeable about the moral and legal rights of all patients to self-determination. The nurse preserves, protects, and supports those interests by assessing the patient's comprehension of both the information presented and the implications of decisions. In situations in which the patient lacks the capacity to make a decision, a designated surrogate decision-maker should be consulted. The role of the surrogate is to make decisions as the patient would, based upon the patient's previously expressed wishes and known values. In the absence of a designated surrogate decision-maker, decisions should be made in the best interests of the patient, considering the patient's personal values to the extent that they are known. The nurse supports patient self-determination by participating in discussions with surrogates, providing guidance and referral to other resources as necessary, and identifying and addressing problems in the decision-making process. Support of autonomy in the broadest sense also includes recognition that people of some cultures place less weight on individualism and choose to defer to family or community values in decision-making. Respect not just for the specific decision but also for the patient's method of decision-making is consistent with the principle of autonomy.

Individuals are interdependent members of the community. The nurse recognizes that there are situations in which the right to individual self-determination may be outweighed or limited by the rights, health and welfare of others, particularly in relation to public health considerations. Nonetheless, limitation of individual rights must always be considered a serious deviation from the standard of care, justified only when there are no less restrictive means available to preserve the rights of others and the demands of justice.

1.5 Relationships with colleagues and others - The principle of respect for persons extends to all individuals with whom the nurse interacts. The nurse maintains compassionate and caring relationships with colleagues and others with a commitment to the fair treatment of individuals, to integrity-preserving compromise, and to resolving conflict. Nurses function in many roles, including direct care provider, administrator, educator, researcher, and consultant. In each of these roles, the nurse treats colleagues, employees, assistants, and students with respect and compassion. This standard of conduct precludes any and all prejudicial actions, any form of harassment or threatening behavior, or disregard for the effect of one's actions on others. The nurse values the distinctive contribution of individuals or groups, and collaborates to meet the shared goal of providing quality health services.

Provision 2 The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

2.1 Primacy of the patient's interests - The nurse's primary commitment is to the recipient of nursing and health care services --the patient--whether the recipient is an individual, a family, a group, or a community. Nursing holds a fundamental commitment to the uniqueness of the individual patient; therefore, any plan of care must reflect that uniqueness. The nurse strives to provide patients with opportunities to participate in planning care, assures that patients find the plans acceptable and supports the implementation of the plan. Addressing patient interests requires recognition of the patient's place in the family or other networks of relationship. When the patient's wishes are in conflict with others, the nurse seeks to help resolve the conflict. Where conflict persists, the nurse's commitment remains to the identified patient.

2.2 Conflict of interest for nurses - Nurses are frequently put in situations of conflict arising from competing loyalties in the workplace, including situations of conflicting expectations from patients, families, physicians, colleagues, and in many cases, health care organizations and health plans. Nurses must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and health care decisions, as well as those of patients. Nurses strive to resolve such conflicts in ways that ensure patient safety, guard the patient's best interests and preserve the professional integrity of the nurse.

Situations created by changes in health care financing and delivery systems, such as incentive systems to decrease spending, pose new possibilities of conflict between economic self-interest and professional integrity. The use of bonuses, sanctions, and incentives tied to financial targets are examples of features of health care systems that may present such conflict. Conflicts of interest may arise in any domain of nursing activity including clinical practice, administration, education, or research. Advanced practice nurses who bill directly for services and nursing executives with budgetary responsibilities must be especially cognizant of the potential for conflicts of interest. Nurses should disclose to all relevant parties (e.g., patients, employers, colleagues) any perceived or actual conflict of interest and in some situations should withdraw from further participation. Nurses in all roles must seek to ensure that employment arrangements are just and fair and do not create an unreasonable conflict between patient care and direct personal-gain.

2.3 Collaboration - Collaboration is not just cooperation, but it is the concerted effort of individuals and groups to attain a shared goal. In health care, that goal is to address the health needs of the patient and the public. The complexity of health care delivery systems requires a multi-disciplinary approach to the delivery of services that has the strong support and active participation of all the health professions. Within this context, nursing's unique contribution, scope of practice, and relationship with other health professions needs to be clearly articulated, represented and preserved. By its very nature, collaboration requires mutual trust, recognition, and respect among the health care team, shared decision-making about patient care, and open dialogue among all parties who have an interest in and a concern for health outcomes. Nurses should work to assure that the relevant parties are involved and have a voice in decision-making about patient care issues. Nurses should see that the questions that need to be addressed are asked and that the information needed for informed decision-making is available and provided. Nurses should actively promote the collaborative multi-disciplinary planning required to ensure the availability and accessibility of quality health services to all persons who have needs for health care.

Intra-professional collaboration within nursing is fundamental to effectively addressing the health needs of patients and the public. Nurses engaged in non-clinical roles, such as administration or research, while not providing direct care, nonetheless are collaborating in the provision of care through their influence and direction of those who do. Effective nursing care is accomplished through the interdependence of nurses in differing roles--those who teach the needed skills, set standards, manage the environment of care, or expand the boundaries of knowledge used by the profession. In this sense, nurses in all roles share a responsibility for the outcomes of nursing care.

2.4 Professional boundaries - When acting within one's role as a professional, the nurse recognizes and maintains boundaries that establish appropriate limits to relationships. While the nature of nursing work has an inherently personal component, nurse-patient relationships and nurse-colleague relationships have, as their foundation, the purpose of preventing illness, alleviating suffering, and protecting, promoting, and restoring the health of patients. In this way, nurse-patient and nurse-colleague relationships differ from those that are purely personal and unstructured, such as friendship. The intimate nature of nursing care, the involvement of nurses is important and sometimes highly stressful life events, and the mutual dependence of colleagues working in close concert all present the potential for blurring of limits to professional relationships. Maintaining authenticity and expressing oneself as an individual, while remaining within the bounds established by the purpose of the relationship can be especially difficult in prolonged or long-term relationships. In all encounters, nurses are responsible for retaining their professional boundaries. When those professional boundaries are jeopardized, the nurse should seek assistance from peers or supervisors or take appropriate steps to remove her/himself from the situation.

Provision 3 The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

3.1 Privacy - The nurse safeguards the patient's right to privacy. The need for health care does not justify unwanted intrusion into the patient's life. The nurse advocates for an environment that provides for sufficient physical privacy, including auditory privacy for discussions of a personal nature and policies and practices that protect the confidentiality of information.

3.2 Confidentiality - Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons.

Information used for purposes of peer review, third-party payments, and other quality improvement or risk management mechanisms may be disclosed only under defined

policies, mandates, or protocols. These written guidelines must assure that the rights, well-being, and safety of the patient are protected. In general, only that information directly relevant to a task or specific responsibility should be disclosed. When using electronic communications, special effort should be made to maintain data security.

3.3 Protection of participants in research - Stemming from the right to self-determination, each individual has the right to choose whether or not to participate in research. It is imperative that the patient or legally authorized surrogate receive sufficient information that is material to an informed decision, to comprehend that information, and to know how to discontinue participation in research without penalty. Necessary information to achieve an adequately informed consent includes the nature of participation, potential harms and benefits, and available alternatives to taking part in the research. Additionally, the patient should be informed of how the data will be protected. The patient has the right to refuse to participate in research or to withdraw at any time without fear of adverse consequences or reprisal.

Research should be conducted and directed only by qualified persons. Prior to implementation, all research should be approved by a qualified review board to ensure patient protection and the ethical integrity of the research. Nurses should be cognizant of the special concerns raised by research involving vulnerable groups, including children, prisoners, students, the elderly, and the poor. The nurse who participates in research in any capacity should be fully informed about both the subject's and the nurse's rights and obligations in the particular research study and in research in general. Nurses have the duty to question and, if necessary, to report and to refuse to participate in research they deem morally objectionable.

3.4 Standards and review mechanisms - Nursing is responsible and accountable for assuring that only those individuals who have demonstrated the knowledge, skill, practice experiences, commitment, and integrity essential to professional practice are allowed to enter into and continue to practice within the profession. Nurse educators have a responsibility to ensure that basic competencies are achieved and to promote a commitment to professional practice prior to entry of an individual into practice. Nurse administrators are responsible for assuring that the knowledge and skills of each nurse in the workplace are assessed prior to the assignment of responsibilities requiring preparation beyond basic academic programs.

The nurse has a responsibility to implement and maintain standards of professional nursing practice. The nurse should participate in planning, establishing, implementing, and evaluating review mechanisms designed to safeguard patients and nurses, such as peer review processes or committees, credentialing processes, quality improvement initiatives, and ethics committees. Nurse administrators must ensure that nurses have access to and inclusion on institutional ethics committees. Nurses must bring forward difficult issues related to patient care and/or institutional constraints upon ethical practice for discussion and review. The nurse acts to promote inclusion of appropriate others in all deliberations related to patient care.

Nurses should also be active participants in the development of policies and review mechanisms designed to promote patient safety, reduce the likelihood of errors, and address both environmental system factors and human factors that present increased risk to patients. In addition, when errors do occur, nurses are expected to follow institutional guidelines in reporting errors committed or observed to the appropriate supervisory personnel and for assuring responsible disclosure of errors to patients. Under no circumstances should the nurse participate in, or condone through silence,

either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error.

3.5 Acting on questionable practice - The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which health care needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state and local laws and regulations, and the employing organization's policies and procedures.

When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice. Attention should be called to the possible detrimental affect upon the patient's well-being or best interests as well as the integrity of nursing practice. When factors in the health care delivery system or health care organization threaten the welfare of the patient, similar action should be directed to the responsible administrator. If indicated, the problem should be reported to an appropriate higher authority within the institution or agency, or to an appropriate external authority.

There should be established processes for reporting and handling incompetent, unethical, illegal, or impaired practice within the employment setting so that such reporting can go through official channels, thereby reducing the risk of reprisal against the reporting nurse. All nurses have a responsibility to assist those who identify potentially questionable practice. State nurses associations should be prepared to provide assistance and support in the development and evaluation of such processes and reporting procedures.When incompetent, unethical, illegal, or impaired practice is not corrected within the employment setting and continues to jeopardize patient well-being and safety, the problem should be reported to other appropriate authorities such as practice committees of the pertinent professional organizations, the legally constituted bodies concerned with licensing of specific categories of health workers and professional practitioners, or the regulatory agencies concerned with evaluating standards or practice. Some situations may warrant the concern and involvement of all such groups. Accurate reporting and factual documentation, and not merely opinion, undergird all such responsible actions. When a nurse chooses to engage in the act of responsible reporting about situations that are perceived as unethical, incompetent, illegal, or impaired, the professional organization has a responsibility to provide the nurse with support and assistance and to protect the practice of those nurses who choose to voice their concerns. Reporting unethical, illegal, incompetent, or impaired practices, even when done appropriately, may present substantial risks to the nurse; nevertheless, such risks do not eliminate the obligation to address serious threats to patient safety.

3.6 Addressing impaired practice - Nurses must be vigilant to protect the patient, the public and the profession from potential harm when a colleague's practice, in any setting, appears to be impaired. The nurse extends compassion and caring to colleagues who are in recovery from illness or when illness interferes with job performance. In a situation where a nurse suspects another's practice may be impaired, the nurse's duty is to take action designed both to protect patients and to assure that the impaired individual receives assistance in regaining optimal function.

Such action should usually begin with consulting supervisory personnel and may also include confronting the individual in a supportive manner and with the assistance of others or helping the individual to access appropriate resources. Nurses are encouraged to follow guidelines outlined by the profession and policies of the employing organization to assist colleagues whose job performance may be adversely affected by mental or physical illness or by personal circumstances. Nurses in all roles should advocate for colleagues whose job performance may be impaired to ensure that they receive appropriate assistance, treatment and access to fair institutional and legal processes. This includes supporting the return to practice of the individual who has sought assistance and is ready to resume professional duties.

If impaired practice poses a threat or danger to self or others, regardless of whether the individual has sought help, the nurse must take action to report the individual to persons authorized to address the problem. Nurses who advocate for others whose job performance creates a risk for harm should be protected from negative consequences. Advocacy may be a difficult process and the nurse is advised to follow workplace policies. If workplace policies do not exist or are inappropriate--that is, they deny the nurse in question access to due legal process or demand resignation--the reporting nurse may obtain guidance from the professional association, state peer assistance programs, employee assistance program or a similar resource.

Provision 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.

4.1 Acceptance of accountability and responsibility - Individual registered nurses bear primary responsibility for the nursing care that their patients receive and are individually accountable for their own practice. Nursing practice includes direct care activities, acts of delegation, and other responsibilities such as teaching, research, and administration. In each instance, the nurse retains accountability and responsibility for the quality of practice and for conformity with standards of care.

Nurses are faced with decisions in the context of the increased complexity and changing patterns in the delivery of health care. As the scope of nursing practice changes, the nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning activities to others who carry out nursing care. For example, some advanced practice nurses have the authority to issue prescription and treatment orders to be carried out by other nurses. These acts are not acts of delegation. Both the advanced practice nurse issuing the order and the nurse accepting the order are responsible for the judgments made and accountable for the actions taken.

4.2 Accountability for nursing judgment and action - Accountability means to be answerable to oneself and others for one's own actions. In order to be accountable, nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of patients. Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of health care organizations' policies or providers' directives.

4.3 Responsibility for nursing judgment and action - Responsibility refers to the specific accountability or liability associated with the performance of duties of a particular role. Nurses accept or reject specific role demands based upon their education, knowledge, competence, and extent of experience. Nurses in administration, education, and research also have obligations to the recipients of

nursing care. Although nurses in administration, education, and research have relationships with patients that are less direct, in assuming the responsibilities of a particular role, they share responsibility for the care provided by those whom they supervise and instruct. The nurse must not engage in practices prohibited by law or delegate activities to others that are prohibited by the practice acts of other health care providers.

Individual nurses are responsible for assessing their own competence. When the needs of the patient are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate sources. Educational resources should be sought by nurses and provided by institutions to maintain and advance the competence of nurses. Nurse educators act in collaboration with their students to assess the learning needs of the student, the effectiveness of the teaching program, the identification and utilization of appropriate resources, and the support needed for the learning process.

4.4 Delegation of nursing activities - Since the nurse is accountable for the quality of nursing care given to patients, nurses are accountable for the assignment of nursing responsibilities to other nurses and the delegation of nursing care activities to other health care workers. While delegation and assignment are used here in a generic moral sense, it is understood that individual states may have a particular legal definition of these terms.

The nurse must make reasonable efforts to assess individual competence when assigning selected components of nursing care to other health care workers. This assessment involves evaluating the knowledge, skills, and experience of the individual to whom the care is assigned, the complexity of the assigned tasks, and the health status of the patient. The nurse is also responsible for monitoring the activities of these individuals and evaluating the quality of the care provided. Nurses may not delegate responsibilities such as assessment and evaluation; they may delegate tasks. The nurse must not knowingly assign or delegate to any member of the nursing team a task for which that person is not prepared or qualified. Employer policies or directives do not relieve the nurse of responsibility for making judgments about the delegation and assignment of nursing care tasks.

Nurses functioning in management or administrative roles have a particular responsibility to provide an environment that supports and facilitates appropriate assignment and delegation. This includes providing appropriate orientation to staff, assisting less experienced nurses in developing necessary skills and competencies, and establishing policies and procedures that protect both the patient and nurse from the inappropriate assignment or delegation of nursing responsibilities, activities, or tasks.

Nurses functioning in educator or preceptor roles may have less direct relationships with patients. However, through assignment of nursing care activities to learners they share responsibility and accountability for the care provided. It is imperative that the knowledge and skills of the learner be sufficient to provide the assigned nursing care and that appropriate supervision be provided to protect both the patient and the learner.

Provision 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.

5.1 Moral self-respect - Moral respect accords moral worth and dignity to all human beings irrespective of their personal attributes or life situation. Such respect extends to oneself as well; the same duties that we owe to others we owe to ourselves. Self-regarding duties refer to a realm of duties that primarily concern oneself and include professional growth and maintenance of competence, preservation of wholeness of character, and personal integrity.

5.2 Professional growth and maintenance of competence - Though it has consequences for others, maintenance of competence and ongoing professional growth involves the control of one's own conduct in a way that is primarily self-regarding. Competence affects one's self-respect, self-esteem, professional status, and the meaningfulness of work. In all nursing roles, evaluation of one's own performance, coupled with peer review, is a means by which nursing practice can be held to the highest standards. Each nurse is responsible for participating in the development of criteria for evaluation of practice and for using those criteria in peer and self-assessment.

Continual professional growth, particularly in knowledge and skill, requires a commitment to lifelong learning. Such learning includes, but is not limited to, continuing education, networking with professional colleagues, self-study, professional reading, certification, and seeking advanced degrees. Nurses are required to have knowledge relevant to the current scope and standards of nursing practice, changing issues, concerns, controversies, and ethics. Where the care required is outside the competencies of the individual nurse, consultation should be sought or the patient should be referred to others for appropriate care.

5.3 Wholeness of character - Nurses have both personal and professional identities that are neither entirely separate, nor entirely merged, but are integrated. In the process of becoming a professional, the nurse embraces the values of the profession, integrating them with personal values. Duties to self involve an authentic expression of one's own moral point-of-view in practice. Sound ethical decision-making requires the respectful and open exchange of views between and among all individuals with relevant interests. In a community of moral discourse, no one person's view should automatically take precedence over that of another. Thus the nurse has a responsibility to express moral perspectives, even when they differ from those of others, and even when they might not prevail.

This wholeness of character encompasses relationships with patients. In situations where the patient requests a personal opinion from the nurse, the nurse is generally free to express an informed personal opinion as long as this preserves the voluntariness of the patient and maintains appropriate professional and moral boundaries. It is essential to be aware of the potential for undue influence attached to the nurse's professional role. Assisting patients to clarify their own values in reaching informed decisions may be helpful in avoiding unintended persuasion. In situations where nurses' responsibilities include care for those whose personal attributes, condition, lifestyle or situation is stigmatized by the community and are personally unacceptable, the nurse still renders respectful and skilled care.

5.4 Preservation of integrity - Integrity is an aspect of wholeness of character and is primarily a self-concern of the individual nurse. An economically constrained health care environment presents the nurse with particularly troubling threats to integrity. Threats to integrity may include a request to deceive a patient, to withhold information, or to falsify records, as well as verbal abuse from patients or coworkers. Threats to integrity also may include an expectation that the nurse will act in a way that is

inconsistent with the values or ethics of the profession, or more specifically a request that is in direct violation of the Code of Ethics. Nurses have a duty to remain consistent with both their personal and professional values and to accept compromise only to the degree that it remains an integrity-preserving compromise. An integrity-preserving compromise does not jeopardize the dignity or well-being of the nurse or others. Integrity-preserving compromise can be difficult to achieve, but is more likely to be accomplished in situations where there is an open forum for moral discourse and an atmosphere of mutual respect and regard.

Where nurses are placed in situations of compromise that exceed acceptable moral limits or involve violations of the moral standards of the profession, whether in direct patient care or in any other forms of nursing practice, they may express their conscientious objection to participation. Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Such grounds exclude personal preference, prejudice, convenience, or arbitrariness. Conscientious objection may not insulate the nurse against formal or informal penalty. The nurse who decides not to take part on the grounds of conscientious objection must communicate this decision in appropriate ways. Whenever possible, such a refusal should be made known in advance and in time for alternate arrangements to be made for patient care. The nurse is obliged to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient.

Where patterns of institutional behavior or professional practice compromise the integrity of all its nurses, nurses should express their concern or conscientious objection collectively to the appropriate body or committee. In addition, they should express their concern, resist, and seek to bring about a change in those persistent activities or expectations in the practice setting that are morally objectionable to nurses and jeopardize either patient or nurse well-being.

Provision 6

The nurse participates in establishing, maintaining, and improving health care 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.

6.1 Influence of the environment on moral virtues and values - Virtues are habits of character that predispose persons to meet their moral obligations; that is, to do what is right. Excellences are habits of character that predispose a person to do a particular job or task well. Virtues such as wisdom, honesty, and courage are habits or attributes of the morally good person. Excellences such as compassion, patience, and skill are habits of character of the morally good nurse. For the nurse, virtues and excellences are those habits that affirm and promote the values of human dignity, well-being, respect, health, independence, and other values central to nursing. Both virtues and excellences, as aspects of moral character, can be either nurtured by the environment in which the nurse practices or they can be diminished or thwarted. All nurses have a responsibility to create, maintain, and contribute to environments that support the growth of virtues and excellences and enable nurses to fulfill their ethical obligations.

6.2 Influence of the environment on ethical obligations - All nurses, regardless of role, have a responsibility to create, maintain, and contribute to environments of

practice that support nurses in fulfilling their ethical obligations. Environments of practice include observable features, such as working conditions, and written policies and procedures setting out expectations for nurses, as well as less tangible characteristics such as informal peer norms. Organizational structures, role descriptions, health and safety initiatives, grievance mechanisms, ethics committees, compensation systems, and disciplinary procedures all contribute to environments that can either present barriers or foster ethical practice and professional fulfillment. Environments in which employees are provided fair hearing of grievances, are supported in practicing according to standards of care, and are justly treatedallow for the realization of the values of the profession and are consistent with sound nursing practice.

6.3 Responsibility for the health care environment - The nurse is responsible for contributing to a moral environment that encourages respectful interactions with colleagues, support of peers, and identification of issues that need to be addressed. Nurse administrators have a particular responsibility to assure that employees are treated fairly and that nurses are involved in decisions related to their practice and working conditions. Acquiescing and accepting unsafe or inappropriate practices, even if the individual does not participate in the specific practice, is equivalent to condoning unsafe practice. Nurses should not remain employed in facilities that routinely violate patient rights or require nurses to severely and repeatedly compromise standards of practice or personal morality.

As with concerns about patient care, nurses should address concerns about the health care environment through appropriate channels. Organizational changes are difficult to accomplish and may require persistent efforts over time. Toward this end, nurses may participate in collective action such as collective bargaining or workplace advocacy, preferably through a professional association such as the state nurses association, in order to address the terms and conditions of employment. Agreements reached through such action must be consistent with the profession's standards of practice, the state law regulating practice and the Code of Ethics for Nursing. Conditions of employment must contribute to the moral environment, the provision of quality patient care and professional satisfaction for nurses.

The professional association also serves as an advocate for the nurse by seeking to secure just compensation and humane working conditions for nurses. To accomplish this, the professional association may engage in collective bargaining on behalf of nurses. While seeking to assure just economic and general welfare for nurses, collective bargaining, nonetheless, seeks to keep the interests of both nurses and patients in balance.

Provision 7 The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

7.1 Advancing the profession through active involvement in nursing and in health care policy - Nurses should advance their profession by contributing in some way to the leadership, activities, and the viability of their professional organizations. Nurses can also advance the profession by serving in leadership or mentorship roles or on committees within their places of employment. Nurses who are self-employed can advance the profession by serving as role models for professional integrity. Nurses can also advance the profession through participation in civic activities related to health care or through local, state, national, or international initiatives. Nurse educators have a specific responsibility to enhance students' commitment to

professional and civic values. Nurse administrators have a responsibility to foster an employment environment that facilitates nurses' ethical integrity and professionalism, and nurse researchers are responsible for active contribution to the body of knowledge supporting and advancing nursing practice.

7.2 Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice - Standards and guidelines reflect the practice of nursing grounded in ethical commitments and a body of knowledge. Professional standards and guidelines for nurses must be developed by nurses and reflect nursing's responsibility to society. It is the responsibility of nurses to identify their own scope of practice as permitted by professional practice standards and guidelines, by state and federal laws, by relevant societal values, and by the Code of Ethics.

The nurse as administrator or manager must establish, maintain, and promote conditions of employment that enable nurses within that organization or community setting to practice in accord with accepted standards of nursing practice and provide a nursing and health care work environment that meets the standards and guidelines of nursing practice. Professional autonomy and self regulation in the control of conditions of practice are necessary for implementing nursing standards and guidelines and assuring quality care for those whom nursing serves.

The nurse educator is responsible for promoting and maintaining optimum standards of both nursing education and of nursing practice in any settings where planned learning activities occur. Nurse educators must also ensure that only those students who possess the knowledge, skills, and competencies that are essential to nursing graduate from their nursing programs.

7.3 Advancing the profession through knowledge development, dissemination, and application to practice - The nursing profession should engage in scholarly inquiry to identify, evaluate, refine, and expand the body of knowledge that forms the foundation of its discipline and practice. In addition, nursing knowledge is derived from the sciences and from the humanities. Ongoing scholarly activities are essential to fulfilling a profession's obligations to society. All nurses working alone or in collaboration with others can participate in the advancement of the profession through the development, evaluation, dissemination, and application of knowledge in practice. However, an organizational climate and infrastructure conducive to scholarly inquiry must be valued and implemented for this to occur.

Provision 8 The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

8.1 Health needs and concerns - The nursing profession is committed to promoting the health, welfare, and safety of all people. The nurse has a responsibility to be aware not only of specific health needs of individual patients but also of broader health concerns such as world hunger, environmental pollution, lack of access to health care, violation of human rights, and inequitable distribution of nursing and health care resources. The availability and accessibility of high quality health services to all people require both interdisciplinary planning and collaborative partnerships among health professionals and others at the community, national, and international levels.

8.2 Responsibilities to the public - Nurses, individually and collectively, have a responsibility to be knowledgeable about the health status of the community and existing threats to health and safety. Through support of and participation in

community organizations and groups, the nurse assists in efforts to educate the public, facilitates informed choice, identifies conditions and circumstances that contribute to illness, injury and disease, fosters healthy life styles, and participatesin institutional and legislative efforts to promote health and meet national health objectives. In addition, the nurse supports initiatives to address barriers to health, such as poverty, homelessness, unsafe living conditions, abuse and violence, and lack of access to health services.

The nurse also recognizes that health care is provided to culturally diverse populations in this country and in all parts of the world. In providing care, the nurse should avoid imposition of the nurse's own cultural values upon others. The nurse should affirm human dignity and show respect for the values and practices associated with different cultures and use approaches to care that reflect awareness and sensitivity.

Provision 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.

9.1 Assertion of values - It is the responsibility of a professional association to communicate and affirm the values of the profession to its members. It is essential that the professional organization encourages discourse that supports critical self-reflection and evaluation within the profession. The organization also communicates to the public the values that nursing considers central to social change that will enhance health.

9.2 The profession carries out its collective responsibility through professional associations - The nursing profession continues to develop ways to clarify nursing's accountability to society. The contract between the profession and society is made explicit through such mechanisms as

    (a) The Code of Ethics for Nurses
    (b) the standards of nursing practice
    (c) the ongoing development of nursing knowledge derived from nursing theory, scholarship, and research in order to guide nursing actions
    (d) educational requirements for practice
    (e) certification, and
    (f) mechanisms for evaluating the effectiveness of professional nursing actions.

9.3 Intraprofessional integrity A professional association is responsible for expressing the values and ethics of the profession and also for encouraging the professional organization and its members to function in accord with those values and ethics. Thus, one of its fundamental responsibilities is to promote awareness of and adherence to the Code of Ethics and to critique the activities and ends of the professional association itself. Values and ethics influence the power structures of the association in guiding, correcting, and directing its activities. Legitimate concerns for the self-interest of the association and the profession are balanced by a commitment to the social goods that are sought. Through critical self-reflection and self-evaluation, associations must foster change within themselves, seeking to move the professional community toward its stated ideals.

9.4 Social reform - Nurses can work individually as citizens or collectively through political action to bring about social change. It is the responsibility of a professional nursing association to speak for nurses collectively in shaping and reshaping health

care within our nation, specifically in areas of health care policy and legislation that affect accessibility, quality, and the cost of health care. Here, the professional association maintains vigilance and takes action to influence legislators, reimbursement agencies, nursing organizations, and other health professions. In these activities, health is understood as being broader than delivery and reimbursement systems, but extending to health-related sociocultural issues such as violation of human rights, homelessness, hunger, violence, and the stigma of illness.

APPENDIX H

CANADIAN NURSES ASSOCIATION CODE OF ETHICS

FOR REGISTERED NURSES

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

File: 490-6

October 27, 2003

Mary McBean, RN, MS ED, MSNc
E-mail: bbygirl2@maxxconnect.net

Subject: Copyright Permission for the CNA Code of Ethics

Dear Mary McBean:

Your request to the Publishing Department has been forwarded to me. Your request use the Canadian Nurses Association's publication entitled "The Code of Ethics for Registered Nurses" in your Masters Thesis Project has been approved. Please ensure that the following conditions are met.

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Rosina Bryantowich, CRM

Canadian Nurses Association Code of Ethics

Preamble

This code of ethics for registered nurses is a statement of the ethical commitments[1] of nurses to those they serve. It has been developed by nurses for nurses and sets forth the ethical standards by which nurses are to conduct their nursing practice.[2]

Purpose of the Code

The code of ethics for registered nurses sets out the ethical behaviour expected of registered nurses in Canada. It gives guidance for decision-making concerning ethical matters, serves as a means for self-evaluation and self-reflection regarding ethical nursing practice and provides a basis for feedback and peer review. The code delineates what registered nurses must know about their ethical responsibilities, informs other health care professionals and members of the public about the ethical commitments of nurses and upholds the responsibilities of being a self-regulating profession. This code serves as an ethical basis from which to advocate for quality practice environments with the potential to impact the delivery of safe, competent and ethical nursing care.

While codes of ethics can serve to guide practice, it takes more than knowledge of general rules to ensure ethical practice. Sensitivity and receptivity to ethical questions must be part of nurses' basic education and should evolve as nurses develop their professional practice. Nursing practice involves attention to ethics at various levels: the individual person, the health care agency or program, the community, society and internationally.

Elements of the code

The elements of this document include:

• A preamble highlighting changes influencing nursing practice;

• A description of the nature of ethics in nursing;

1. In this document the terms moral and ethical are used interchangeably based upon consultation with nurse-ethicists and philosophers, while acknowledging that not everyone shares this usage.

2. In this document, nursing practice refers to all nurses' professional activities, inclusive of nursing education, administration, research and clinical or public health practice.

- A definition of values and the importance of relationships for ethical practice;

- A description of the eight values of the code;

- Explanatory responsibility statements based upon each value;

- Glossary;

- Specific applications of the code (Appendix A);

- The code of ethics history (Appendix B); and

- Ethics reading resources.

Context of the Code

The Canadian Nurses Association's (CNA's) code of ethics reflects changes in social values and conditions that affect the health care system and create both new challenges and opportunities for the ethical practice of nursing. Examples of such challenges and opportunities are briefly below.

- Nurses have become more autonomous in their practice as a function of the development of nursing knowledge and research and changing patterns of care. For example, day surgeries and shortened lengths of stays have lead to nurses caring for people with complex care needs across acute, continuing, community and home care settings. With less direct supervision, greater individual accountability for safe, competent and ethical care is needed.

- Nurses have greater opportunities to provide benefit to people and communities through integrated team work. Effective team work requires clear and respectful communication which is essential to providing quality care. This goal has been difficult to achieve due to fiscal and systemic constraints.

- Traditionally nurses have been leaders in health promotion and primary health care, often in remote areas, and now increasingly in the community. These roles have become more important in the evolving climate of health care reform. Further, the emergence of communicable diseases, once thought conquered, and new infectious diseases have created serious public health challenges and reinforces the reality of the global community.

- The biological/genetic revolution, as well as other emerging technologies, raise profound changes in the human capacity to control disease and human reproduction as well as to govern access to health information. Comparable philosophical development in considering the ethics of these advances is, as yet, limited. The public needs knowledge and ethical guidance to make well-informed choices about the appropriate use of many of these advances.

- The adoption of a business approach to health care reform involves values of efficiency guided by outcome measures and often a re-orientation of priorities. Many have concerns that the values inherent in an industrial and/or for-profit approach could replace fundamental values underlying health care in Canada, such as provision for the care of vulnerable persons (eg. elderly), enhancing quality of life and solidarity in community. This might reflect a shift in public values.

The Nature of Ethics in Nursing

The ability of nurses to engage in ethical practice in everyday work and to deal with ethical situations, problems and concerns can be the result of decisions made at a variety of levels – individual, organizational, regional, provincial, national and international. Differing responsibilities, capabilities and ways of working toward change also exist at these various levels. For all contexts and levels of decision-making, the code offers guidance for providing care that is congruent with ethical practice and for actively influencing and participating in policy development, review and revision.

The complex issues in nursing practice have both legal and ethical dimensions. An ideal system of law would be compatible with ethics, in that adherence to the law should never require the violation of ethics. There may be situations in which nurses need to take collective action to change a law that is incompatible with ethics. Still, the domains of law and ethics remain distinct, and the code addresses ethical responsibilities only.

Ethical Situations

In their practice, nurses constantly face situations involving ethics. These can be described in several ways. Description allows nurses to *name* their source of discomfort, a first step in addressing these ethical situations.

Everyday ethics: the way nurses approach their practice and reflect on their ethical commitment to the people[3] they serve. It involves the nurses' attention to common ethical events such as protecting a person's physical privacy.

Ethical violations: neglecting fundamental nursing obligations in a situation where the nurse knows that the action or lack of action is not appropriate.

Ethical dilemmas: situations arising when equally compelling ethical reasons both for and against a particular course of action are recognized and a decision must be made, for example, caring for a young teenager who is refusing treatment.

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3. In this document the terms 'people they serve', 'person' or 'individual' refers to the patient, the client, the individual, family, group or community for whom care and/or health promotion assistance is provided.

Ethical distress: situations in which nurses cannot fulfill their ethical obligations and commitments (i.e. their moral agency), or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectation of ethical practice, for one or more of the following reasons: error in judgment, insufficient personal resolve or other circumstances truly beyond their control (Webster & Baylis, 2000). They may feel guilt, concern or distaste as a result.

Moral residue: "...that which each of us carries with us from those times in our lives when in the face of ethical distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Baylis, 2000, p. 218). Moral residue may, for example, be an outcome for some nurses who are required to implement behaviour modification strategies in the treatment of mentally ill persons (Mitchell, 2001).

Ethical uncertainty: arises when one is unsure what ethical principles or values to apply or even what the moral problem is (Jameton, 1984).

Nurses may experience ethical situations differently. Regardless of this, the code provides guidelines for reflection and guides to action, and is intended to assist nurses through these experiences. Naming situations can be a turning point from which nurses can begin to address difficult situations, for example, dealing with ethical distress and moral residue can often lead to "defining moments" in one's career (e.g., if the nurse determines that this specific situation shall not occur again), thus allowing for positive outcomes to emerge from a difficult experience.

Ethical Decision-making

The *Code of Ethics for Registered Nurses* is structured around eight primary values that are central to ethical nursing practice:

- Safe, competent and ethical care
- Health and well-being
- Choice
- Dignity
- Confidentiality
- Justice
- Accountability
- Quality practice environments

With each value, specific responsibility statements are provided. Ethical reflection, which begins with a review of one's own ethics, and judgment are required to determine how a particular value or responsibility applies in a particular nursing context. There is room within the profession for disagreement among nurses about the relative weight of different ethical values and principles. More than one proposed intervention may be ethical and reflective of good practice. Discussion and questioning are extremely helpful in the resolution of ethical issues. As appropriate, persons in care, colleagues in nursing and other disciplines, professional nurses' associations, colleges, ethics committees and other experts should be included in discussions about ethical problems. In addition legislation, standards of practice, policies and guidelines of professional nurses' associations, colleges and nurses' unions may also assist in problem-solving. Further, models for ethical decision-making, such as those described in CNA's *Everyday Ethics*, can assist nurses in thinking through ethical problems.

Values

A value is a belief or attitude about the importance of a goal, an object, a principle or a behaviour. People may hold conflicting values and often may not be aware of their own values. Values refer to ideals that are desirable in themselves and not simply as a means to get something else. The values articulated in this code are grounded in the professional nursing relationship with individuals and indicate what nurses care about in that relationship. For example, to identify health and well-being as a value is to say that nurses care for and about the health and well-being of the people they serve. This relationship presupposes a certain measure of trust on the part of the person served. Care and trust complement one another in professional nursing relationships. Both hinge on the values identified in the code. By upholding these values in practice, nurses earn and maintain the trust of those in their care. For each of the values, the scope of responsibilities identified extends beyond individuals to include families, communities and society.

It should be noted that nurses' responsibilities to enact the values of the code cannot be separated from the responsibilities for other health care providers, health care agencies and policy makers at regional, provincial, national and international levels to foster health care delivery environments supporting ethical practice. While the code cannot enforce responsibilities outside of nursing, it can provide a powerful political instrument for nurses when they are concerned about being able to practice ethically.

Nursing Values Defined

Safe, competent and ethical care

Nurses value the ability to provide safe, competent and ethical care that allows them to fulfill their ethical and professional obligations to the people they serve.

Health and well-being

Nurses value health promotion and well-being and assisting persons to achieve their optimum level of health in situations of normal health, illness, injury, disability or at the end of life.

Choice

Nurses respect and promote the autonomy of persons and help them to express their health needs and values and also to obtain desired information and services so they can make informed decisions.

Dignity

Nurses recognize and respect the inherent worth of each person and advocate for respectful treatment of all persons.

Confidentiality

Nurses safeguard information learned in the context of a professional relationship, and ensure it is shared outside the health care team only with the person's informed consent, or as may be legally required, or where the failure to disclose would cause significant harm.

Justice

Nurses uphold principles of equity and fairness to assist persons in receiving a share of health services and resources proportionate to their needs and in promoting social justice.

Accountability

Nurses are answerable for their practice, and they act in a manner consistent with their professional responsibilities and standards of practice.

Quality Practice Environments

Nurses value and advocate for practice environments that have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting.

Nursing Values and Responsibility Statements

Safe, Competent and Ethical Care

Nurses value the ability to provide safe, competent and ethical care that allows them to fulfill their ethical and professional obligations to the people they serve.

1. Nurses must strive for the highest quality of care achievable.

2. Nurses must recognize that they have the ability to engage in determining and expressing their own moral choices. Their moral choices may be influenced by external factors (e.g. institutional values and constraints).

3. Nurses should be sufficiently clear and reflective about their personal values to recognize potential value conflicts.

4. Nurses must maintain an acceptable level of health and well-being in order to provide a competent level of service/care for the people they serve.

5. Nurses must base their practice on relevant research findings and acquire new skills and knowledge in their area of practice throughout their career.

6. Nurses must practice within their own level of competence. When aspects of care are beyond their level of competence, they must seek additional information or knowledge, seek help from their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses must provide care until another nurse is available to do so.

7. Nurses seeking professional employment must accurately state their area(s) of competence. They should seek reasonable assurance that employment conditions will permit care consistent with the values and responsibilities of the code.

8. Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event.

9. Nurses must strive to prevent and minimize adverse events[4] in collaboration with colleagues on the health care team. When adverse events occur, nurses should utilize opportunities to improve the system and prevent harm.

4. Adverse events include physician and interdisciplinary team error.

10. All nurses must contribute to safe and supportive work environments.

11. Nurse leaders have a particular obligation to strive for safe practice environments that support ethical practice.

12. Nurses should advocate for ongoing research designed to identify best nursing practices and for the collection and interpretation of nursing care data at a national level.

Health and Well-being

Nurses value health promotion and well-being and assisting persons to achieve their optimum level of health in situations of normal health, illness, injury, disability or at the end of life.

1. Nurses must provide care directed first and foremost toward the health and well-being of the person, family or community in their care.

2. Nurses must recognize that health is more than the absence of disease or infirmity and must work in partnership with people to achieve their goals of maximum health and well-being.

3. Nurses should provide care addressing the well-being of the person in the context of that person's relationships with their family and community.

4. Nurses must foster comfort and well-being when persons are terminally ill and dying to alleviate suffering and support a dignified and peaceful death.

5. Nurses should provide the best care that circumstances permit even when the need arises in an emergency outside an employment situation.

6. Nurses should respect and value the knowledge, skills and perspectives of the persons in their care and must recognize, value and respect these while planning for and implementing care.

7. In providing care, nurses should also respect and value the knowledge and perspectives of other health providers. They should actively collaborate and where possible seek appropriate consultations and referrals to other health team members in order to maximum health benefits to people.

8. Nurses should recognize the need to address organizational, social, economic and political factors influencing health. They should participate with their colleagues, professional associations, colleges and other groups to present nursing views in ways that are consistent with their professional role, responsibilities and capabilities and which are in the interests of the public.

9. Nurses should recognize the need for a full continuum of accessible health services, including health promotion and disease prevention initiatives, as well as diagnostic, restorative, rehabilitative and palliative care services.

10. Nurses should seek ways to improve access to health care that enhances, not replaces, care by utilizing new research based technologies, such as telehealth (eg. telephone assessment and support).

11. Nurses should continue to contribute to and support procedurally and ethically rigorous research and other activities that foster the ongoing development of nursing knowledge.

12. Nurses who conduct or assist in the conduct of research must observe the nursing profession's guidelines, as well as other guidelines, for ethical research.[5]

Choice

Nurses respect and promote the autonomy of persons and help them to express their health needs and values and also to obtain desired information and services so that they can make informed decisions.

1. Nurses must be committed to building trusting relations as the foundation of meaningful communication, recognizing that building this relationship takes effort. Such relationships are critical to ensure that a person's choice is understood, expressed and advocated.

2. Nurses should provide the desired information and support required so people are enabled to act on their own behalf in meeting their health and health care needs to the greatest extent possible.

3. Nurses should be active in assisting person's to obtain the best current knowledge about their health condition.

4. Nurses must respect the wishes of those who refuse, or are not ready, to receive information about their health condition. They should be sensitive to the timing of information given and how the information is presented.

5. Nurses must ensure that nursing care is provided with the person's informed consent. Nurses must also recognize that persons have the right to refuse or withdraw consent for care or treatment at any time.

5. Please see CNA's *Ethical Research Guidelines for Registered Nurses*, 3rd ed. (2002) for full details.

6. Nurses must respect the informed choices of those with decisional capacity to be independent, to choose lifestyles not conducive to good health and to direct their own care as they see fit. However, nurses are not obligated to comply with a person's wishes when this is contrary to the law.

7. Nurses must continue to provide opportunities for people to make choices and maintain their capacity to make decisions, even when illness or other factors reduce the person's capacity for self-determination. Nurses should seek assent of the person when consent is not possible.

8. If nursing care is requested that is contrary to the nurse's personal values, the nurse must provide appropriate care until alternative care arrangements are in place to meet the person's desires.

9. Nurses must be sensitive to their position of relative power in professional relationships with persons. Nurses must also identify and minimize (and discuss with the health team) sources of coercion.

10. Nurses must respect a person's advance directives about present and future health care choices that have been given or written by a person prior to loss of decisional capacity.

11. When a person lacks decisional capacity, nurses must obtain consent for nursing care from a substitute decision-maker, subject to the laws in their jurisdiction. When prior wishes for treatment and care of an incompetent person are not known or are unclear, nurses' decisions must be made based on what the person would have wanted as far as is known, or failing that, decisions must be made in the best interest of the person in consultation with the family and other health care providers.

12. Nurses should respect a person's method of decision-making, recognizing that different cultures place different weight on individualism and often choose to defer to family and community values in decision-making (ANA, 2001). However, nurses should also advocate for the individual if that person's well-being is compromised by family, community or other health professionals.

Dignity

Nurses recognize and respect the inherent worth of each person and advocate for respectful treatment of all persons.

1. Nurses must relate to all persons receiving care as persons worthy of respect and endeavour in all their actions to preserve and demonstrate respect for the dignity and rights of each individual.

2. Nurses must be sensitive to an individual's needs, values and choices. Nurses should take into account the biological, psychological, social, cultural and spiritual needs of persons in health care.

3. Nurses must recognize the vulnerability of persons and must not exploit their vulnerabilities for the nurse's own interest or in a way that might compromise the therapeutic relationship. Nurses must maintain professional boundaries to ensure their professional relationships are for the benefit of the person they serve. For example, they must avoid sexual intimacy with patients, avoid exploiting the trust and dependency of persons in their care and must not use their professional relationships for personal or financial gain.

4. Nurses must respect the physical privacy of persons when care is given, by providing care in a discreet manner and by minimizing unwanted intrusions.

5. Nurses must intervene if others fail to respect the dignity of persons in care.

6. Nurses must advocate for appropriate use of interventions in order to minimize unnecessary and unwanted procedures that may increase suffering.

7. Nurses must seek out and honour persons' wishes regarding how they want to live the remainder of their life. Decision-making about life sustaining treatment is guided by these considerations.

8. Nurses should advocate for health and social conditions that allow persons to live and die with dignity.

9. Nurses must avoid engaging in any form of punishment, unusual treatment or action that is inhuman or degrading towards the persons in their care and must avoid complicity in such behaviours.

Confidentiality

Nurses safeguard information learned in the context of a professional relationship and ensure it is shared outside the health care team only with the person's informed consent, or as may be legally required, or where the failure to disclose would cause significant harm.

1. Nurses must respect the right of each person to informational privacy, that is, the individual's control over the use, access, disclosure and collection of their information.

2. Nurses must advocate for persons requesting access to their health record subject to legal requirements.

3. Nurses must protect the confidentiality of all information gained in the context of the professional relationship, and practice within relevant laws governing privacy and confidentiality of personal health information.

4. Nurses must intervene if other participants in the health care delivery system fail to maintain their duty of confidentiality.

5. Nurses must disclose a person's health information only as authorized by that person, unless there is substantial risk of serious harm to the person or to other persons or a legal obligation to disclose. Where disclosure is warranted, information provided must be limited to the minimum amount of information necessary to accomplish the purpose for which it has been disclosed. Further the number of people informed must be restricted to the minimum necessary.

6. Nurses should inform the persons in their care that their health information will be shared with the health care team for the purposes of providing care. In some circumstances nurses are legally required to disclose confidential information without consent. When this occurs nurses should attempt to inform individuals about what information will be disclosed, to whom and for what reason(s).

7. When nurses are required to disclose health information about persons, with or without the person's informed consent, they must do so in ways that do not stigmatize individuals, families or communities. They must provide information in a way that minimizes identification as much as possible.

8. Nurses must advocate for and respect policies and safeguards to protect and preserve the person's privacy.

Justice

Nurses uphold principles of equity and fairness to assist persons in receiving a share of health services and resources proportionate to their needs and promoting social justice.

1. Nurses must not discriminate in the provision of nursing care based on a person's race, ethnicity, culture, spiritual beliefs, social or marital status, sex, sexual orientation, age, health status, lifestyle, mental or physical disability and/or ability to pay.

2. Nurses must strive to make fair decisions about the allocation of resources under their control based upon the individual needs of persons in their care.

3. Nurses should put forward, and advocate for, the interests of all persons in their care. This includes helping individuals and groups gain access to appropriate health care that is of their choosing.

4. Nurses should promote appropriate and ethical care at the organizational/agency and community levels by participating in the development, implementation and ongoing review of policies and procedures designed to provide the best care for persons with the best use of available resources given current knowledge and research.

5. Nurses should advocate for health policies and decision-making procedures that are consistent with current knowledge and practice.

6. Nurses should advocate for fairness and inclusiveness in health resource allocation, including policies and programs addressing determinants of health, along with research based technology and palliative approaches to health care.

7. Nurses should be aware of broader health concerns such as environmental pollution, violations of human rights, world hunger, homelessness, violence, etc. and are encouraged to the extent possible in their personal circumstances to work individually as citizens or collectively for policies and procedures to bring about social change, keeping in mind the needs of future generations (ANA, 2001).

Accountability

Nurses are answerable for their practice, and they act in a manner consistent with their professional responsibilities and standards of practice.

1. Nurses must respect and practice according to the values and responsibilities in this *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice. They should use opportunities to help nursing colleagues be aware of this code and other professional standards.

2. Nurses have the responsibility to conduct themselves with honesty and to protect their own integrity in all of their professional interactions.

3. Nurses, in clinical, administrative, research or educational practice, have professional responsibilities and accountabilities toward safeguarding the quality of nursing care persons receive. These responsibilities vary, but all must be oriented to the expected outcome of safe, competent and ethical nursing practice.

4. Nurses should share their knowledge and provide mentorship and guidance for the professional development of nursing students and other colleagues/health care team members.

5. Nurse educators, to the extent possible, must ensure that students will possess the required knowledge, skills and competencies in order to graduate from nursing programs (ANA, 2001).

6. Nurse administrators/managers, to the extent possible, must ensure that only those nurses possessing the required knowledge, skills and competencies work in their practice areas.

7. Nurses should provide timely and accurate feedback to other nurses and colleagues in other disciplines and students about their practice, so as to support and recognize safe and competent practice, contribute to ongoing learning and improve care.

8. If nurses determine that they do not have the necessary physical, mental or emotional well-being to provide safe and competent care to persons, they may withdraw from the provision of care or decline to engage in care. However, they must first give reasonable notice to the employer, or if self-employed to their patients, and take reasonable action to ensure that appropriate action has been taken to replace them (RNABC, 2001).

9. Nurses planning to participate in job action or who practice in environments where job action occurs, must take steps (see Appendix A) to safeguard the health and safety of people during the course of the job action.

10. Nurses must give primary consideration to the welfare of the people they serve and to any possibility of harm in future care situations when they are pondering taking action with regard to suspected unethical conduct or incompetent or unsafe care. When nurses have reasonable grounds for concern about the behaviour of colleagues or about the safety of conditions in the care setting, they must carefully review the situation and take steps, individually or in partnership with others, to resolve the problem (see Appendix A).

11. Nurses should advocate for discussion of ethical issues among health team members, patients and families.

12. Nurses should advocate for changes to policy, legislation or regulations in concert with other colleagues and their professional associations or colleges, when there is agreement that these directives are unethical.

Quality Practice Environments

Nurses value and advocate for quality practice environments that have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting.

1. Nurses must advocate, to the extent possible within the circumstances, for sufficient human and material resources to provide safe and competent care.

2. Nurses individually or in partnership with others, must take preventive as well as corrective action to protect persons from incompetent, unethical or unsafe care.

3. If working short staffed, nurses must set priorities reflecting the allocation of resources. In such cases, nurses must endeavour to keep patients, families and employers informed about potential and actual changes to usual routines (CRNM, 2000).

4. Nurses must support a climate of trust that sponsors openness, encourages questioning the status quo and supports those who speak out publicly in good faith (e.g. whistle blowing). It is expected that nurses who engage in responsible reporting of incompetent, unsafe or unethical care or circumstances will be supported by their professional association.

5. Nurses must advocate for work environments in which nurses and other health workers are treated with respect and support when they raise questions or intervene to address unsafe or incompetent practice.

6. Nurses must seek constructive and collaborative approaches to resolve differences impacting upon care amongst members of the health care team and commit to compromise and conflict resolution.

7. Nurses are justified in using reasonable means to protect against violence when, following an informed assessment, they anticipate acts of violence toward themselves, others or property. In times when violence cannot be prevented or anticipated nurses are justified in taking self-protective action.

8. Nurse managers/administrators must strive to provide adequate staff to meet the requirements for nursing care as part of their fundamental responsibility to promote practice environments where fitness to practice and safe care can be maintained (AARN, 2001). With their staff, they should work towards the development of a moral community.[6]

9. As part of a moral community, nurses acknowledge their responsibility in contributing to quality practice settings that are positive, healthy working environments.

10. Nurses should collaborate with nursing colleagues and other members of the health team to advocate for health care environments conducive to ethical practice and to the health and well-being of clients and others in the setting. They do this in ways that are consistent with their professional role and responsibilities.

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6. A moral community is one where there is coherence between what the agency publicly professes to be their goal and what employees, persons in care, and others witness and participate in (Webster & Baylis, 2000). A moral community for nurses would include, for example, a community in which the development of effective teams was fostered, ethics education opportunities were available and provision was made for ethics rounds and/or an ethics committee.

Glossary

Accountability: the state of being answerable to someone for something one has done (Burkhardt & Nathaniel, 2002).

Advance Directives: a person's written wishes about life-sustaining treatment meant to assist with decisions about withholding or withdrawing treatment (Storch, Rodney & Starzomski, 2002). Also called living wills or anticipatory health plans.

Assent: the agreement by a child or incapacitated person to a therapeutic procedure or involvement in research following the receipt of good information. Assent from the individual affected is encouraged in addition to informed consent from the guardian or parent.

Autonomy: self-determination; an individual's right to make choices about one's own course of action (AARN, 1996).

Belief: a conviction that something is true (AARN, 1996).

Confidentiality: means the duty to preserve a person's privacy.

Consent: see informed consent.

Ethical: a formal process for making logical and consistent decisions based upon ethical values.

Ethical Commitment: ethical obligations health providers have to those they serve.

Ethical/Moral Uncertainty: arises when one is unsure what ethical principles or values to apply or even what the ethical problem is (Jameton, 1984).

Fair: equalizing people's opportunities to participate in and enjoy life, given their circumstances and capacities (Caplan, Light & Daniels, 1999).

Health Care Team: a number of health care providers from different disciplines working in collaboration to provide care for individuals, families or the community.

Informational Privacy: is the right of persons to control the use, access, disclosure and collection of their information.

Informed Consent: a legal doctrine based on respect for the principle of autonomy of an individual's right to information required to make decisions.

Justice: a principle focusing on fair treatment of individuals and groups within society. Justice is a broader concept than fairness, one example of its application is the just allocation of resources at a societal level.

Moral Agent/Agency: The concept of moral agency reflects a notion of individuals engaging in self-determining or self-expressive ethical choice. Moral agency designates nurses enacting their professional responsibility and accountability through relationships in particular contexts. A moral agent is the individual involved in fulfilling moral agency (Rodney & Starzomski, 1993).

Moral Community: is a community in which there is coherence between what a healthcare organization publicly professes to be, i.e. a helping, healing, caring environment that embraces values intrinsic to the practice of healthcare, and what employees, patients and others both witness and participate in (Webster & Baylis, 2000).

Moral Residue: "... that which each of us carries from those times in our lives when in the face of ethical distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster and Baylis, 2000, p. 218).

Nurse: Refers to registered nurse.

Physical privacy: refers to withdrawing or being protected from public view, particularly applicable to protecting persons from exposure while providing body care.

Social justice: involves attention to those who are most vulnerable in society, e.g. those who have been excluded or forgotten due to handicap, limited education or failing health.

Appendix A
Suggestions for Application of the Code in Selected Circumstances

Steps to address incompetent, unsafe and unethical care

- Gather the facts about the situation and ascertain the risks and undertake to resolve the problem;

- Review relevant legislation and policies, guidelines and procedures for reporting incidents or suspected incompetent or unethical care and report, as required, any legally reportable offence;

- Seek relevant information directly from the colleague whose behaviour or practice has raised concerns, when this is feasible;

- Consult, as appropriate, with colleagues, other members of the team, professional nurses' associations, colleges or others able to assist in resolving the problem;

- Undertake to resolve the problem as directly as possible consistent with the good of all parties;

- Advise the appropriate parties regarding unresolved concerns and, when feasible, inform the colleague in question of the reasons for your action;

- Refuse to participate in efforts to deceive or mislead persons about the cause of alleged harm or injury resulting from unethical or incompetent conduct.

Nurse managers/administrators, professional associations and client safety

- Nurse managers/administrators seek to ensure that available resources and competencies of personnel are used efficiently;

- Nurse managers/administrators intervene to minimize the present danger and to prevent future harm when persons safety is threatened due to inadequate resources or for some other reason;

- Professional nurses' associations support individual nurses and groups of nurses in promoting fairness and inclusiveness in health resource allocation. They do so in ways that are consistent with their role and functions.

Considerations in student-teacher-client relationships.

- Student-teacher and student-client encounters are essential elements of nursing education and are conducted in accordance with ethical nursing practices;

- Persons are informed of the student status of the care giver and consent for care is obtained in compliance with accepted standards;

- Students of nursing are treated with respect and honesty by nurses and are given appropriate guidance for the development of nursing competencies;

- Students are acquainted with and comply with the provisions of the code.

Considerations in taking job action

- Job action by nurses is often directed toward securing conditions of employment that enable safe and ethical care of current and future patients. However, action directed toward such improvements could work to the detriment of patients in the short term.

- Individual nurses and groups of nurses safeguard patients in planning and implementing any job action.

- Individuals and groups of nurses participating in job action, or affected by job action, share the ethical commitment to person's safety. Their particular responsibilities may lead them to express this commitment in different but equally appropriate ways.

- Persons whose safety requires ongoing or emergency nursing care are entitled to have those needs satisfied throughout any job action.

- Members of the public are entitled to information about the steps taken to ensure the safety of persons during any job action.

Appendix B
A Code of Ethics History

1954   CNA adopts the ICN Code as its first Code of Ethics

1980   CNA moves to adopt its own code entitled, *CNA Code of Ethics: An Ethical Basis for Nursing in Canada*

1985   CNA adopts new code called, *Code of Ethics for Nursing*

1991   *Code of Ethics for Nursing* revised

1997   *Code of Ethics for Registered Nurses* adopted as updated code for CNA

2002   *Code of Ethics for Registered Nurses* revised

The Canadian Nurses Association prepares position papers, ethics-issue specific practice papers, an ethical dilemma column in the *Canadian Nurse* journal, an ethics listserv, booklets and other ethics related resources. In addition, CNA works with other health professional associations and colleges to develop interprofessional statements (e.g. about no resuscitation policies, resolving conflict) related to issues or concerns of an ethical nature.

References

Alberta Association of Registered Nurses. (1996). *Ethical decision-making for registered nurses in Alberta: Guidelines and recommendations.* Edmonton: Author.

Alberta Association of Registered Nurses. (2001). *Working extra hours: Guidelines for registered nurses on fitness to practice and the provision of safe, competent, ethical nursing care.* Edmonton: Author.

American Nurses Association. (2001). *American Nurses Association code of ethics.* Washington: Author.

Burkhardt, M. A. & Nathaniel, A.K. (1998). *Ethics & issues in contemporary nursing.* Toronto: Delmar Publishers.

Canadian Nurses Association. (2002). *Ethical research guidelines for registered nurses* (3rd ed.). Ottawa: Author.

Caplan, R. L., Light, D. W. & Daniels, N. (1999). Benchmarks of fairness: A moral framework for assessing equity. *International Journal of Health Services,* 29(4): 853-869.

College of Registered Nurses of Manitoba. (2002). *Working short staffed.* Winnipeg: Author.

Jameton, A. (1984). *Nursing Practice: The ethical issues.* Englewood Cliffs, N.J.: Prentice Hall.

Mitchell, G. J. (2001). Policy, procedure, and routine: Matters of moral influence. *Nursing Science Quarterly,* 14(2): 109-114.

Registered Nurses Association of British Columbia. (2001). *Nursing Practice guidelines: Duty to provide care.* Vancouver: Author.

Rodney, P. & Starzomski, R. (1993). Constraints on moral agency of nurses. *Canadian Nurse,* 89(9), 23-26.

Storch, J., Rodney, P. & Starzomski, R. (2002). Ethics in health care in Canada. In B.S. Bolaria & H. Dickinson (Eds.), *Health, illness and health care in Canada* (3rd edition, pp. 409-444). Scarborough, On: Nelson Thomas Learning.

Webster, G. & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

Ethics Reading Resources

CNA Resources

Canadian Dental Association, Canadian Medical Association, Canadian Pharmacists Association, Canadian Health Care Association, Canadian Nurses Association, Consumer Association of Canada. (2000). *Principles for privacy protection of personal health information in Canada.* Ottawa: Authors.

Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association, Catholic Health Association of Canada (with Canadian Bar Association). (1995). *Joint statement on resuscitative interventions.* Ottawa: Authors.

Canadian Home Care Association, Canadian Healthcare Association, Canadian Long Term Care Association, Canadian Nurses Association, Canadian Public Health Association, Home Support Canada. (1994). *Joint statement on advance directives.* Ottawa: Authors.

Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association, Catholic Health Association of Canada. (1999). *Joint statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care.* Ottawa: Authors.

Canadian Nurses Association. (1992). *The role of the nurse in the use of health care technology.* Ottawa: Author.

Canadian Nurses Association. (1994). *A question of respect: Nurses and end-of-life treatment dilemmas.* Ottawa: Author.

Canadian Nurses Association. (1998, May). Advance directives: The nurse's role. *Ethics in Practice.*

Canadian Nurses Association. (1998, June). Ethical issues related to appropriate staff mixes. *Ethics in Practice.*

Canadian Nurses Association. (1998). *Everyday ethics: Putting the code into practice.* Ottawa: Author.

Canadian Nurses Association. (1999, November). I see and am silent / I see and speak out: The ethical dilemma of whistleblowing. *Ethics in Practice.*

Canadian Nurses Association. (2000, September). Working with limited resources: Nurses' moral constraints. *Ethics in Practice.*

Canadian Nurses Association. (2001). *Nursing professional regulatory framework.* Ottawa: Author.

Canadian Nurses Association. (2001). *Privacy of personal health information*. Ottawa: Author.

Canadian Nurses Association. (2001). *Quality professional practice environments for registered nurses*. Ottawa: Author.

Canadian Nurses Association. (2001). *The role of the nurse in telepractice*. Ottawa: Author.

Canadian Nurses Association. (2001, May). Futility presents many challenges for nurses. *Ethics in Practice.*

Canadian Nurse – *Ethical Dilemma Columns*

Ellerton, M. L. (2000). When parents and children disagree about care. *Canadian Nurse, 96*(7), 35-36.

Ellerton, M. L. (2002). Client restraints: More than a safety issue. *Canadian Nurse, 98*(2), 32-33.

McAlpine, H. (2001). Refusal to care. *Canadian Nurse, 97*(6), 33-34.

Moorhouse, A. (2001). When CPR is not an option. *Canadian Nurse, 97*(1), 37-38.

Storch, J. (2000). Exposure to body fluids. *Canadian Nurse, 96*(6), 35-36.

Storch, J. (2002). When a client considers surrogacy. *Canadian Nurse, 98*(5), 32-33.

Infirmière canadienne – *Articles on ethics*

Saint-Arnaud, J. Technologies biomédicales et enjeux éthiques en soins infirmiers : La fin justifie-t-elle les moyens?, *infirmière canadienne*, 3 (4), 2002, p. 4-8.

Saint-Arnaud, J. Technologies biomédicales et enjeux éthiques en soins infirmiers : La vie, oui... mais à quel prix?, *infirmière canadienne*, 3 (3), 2002, p. 4-8.

Pelletier, C. Recherche sur la maltraitance infantile : Les incontournables de l'éthique, *infirmière canadienne*, 2 (6), 2001, p. 4-8.

Saint-Arnaud, J. Les théories éthiques et l'éthique des soins, *infirmière canadienne*, 2 (2), 2001, p. 8-10.

Saint-Arnaud, J. Pourquoi une chronique en éthique des soins?, *infirmière canadienne*, 1 (3), 2000, p. 10-11.

Provincial and Territorial Resources

Alberta Association of Registered Nurses. (1997). *Professional boundaries: A discussion paper on expectations for nurse-client relationships.* Edmonton: Author.

College of Nurses of Ontario. (1999). *Ethical framework for nurses in Ontario.* Toronto: Author.

College of Registered Nurses of Manitoba. (2002). *Professional boundaries for therapeutic relationships.* Winnipeg: Author.

Registered Nurses Association of British Columbia. (2000). *Advocacy and the registered nurse.* Vancouver: Author.

Registered Nurses Association of Nova Scotia. (1996). *Violence in the workplace: A resource guide.* Halifax: Author.

Registered Nurses Association of Nova Scotia. (2000). *Guidelines for telenursing practice.* Halifax: Author.

Other Resources

Nurses may consult with members of the health team, ethics committees, practice consultants at associations and colleges, religious leaders etc.

Austin, W. (2001). Nursing ethics in an era of globalization. *Advances in Nursing Science, 24*(2), 1-18.

Canadian Nurses Protective Society. (1993, September). Confidentiality of health information: Your client's right. *Info Law, 1*(2).

Canadian Nurses Protective Society. (1994, December). Consent to treatment: The role of the nurse. *Info Law, 3*(2).

Corley, M.C. & Goren, S. (1998). The dark side of nursing: Impact of stigmatizing responses on patients. *Scholarly Inquiry for Nursing Practice, 12*(2), 99-122.

International Council of Nurses. (1999). *Guidelines on coping with violence in the workplace.* Geneva: Author.

International Council of Nurses. (2000). *The ICN code of ethics for nurses.* Geneva: Author.

Johnstone, M. J. (1999). *Bioethics: A nursing perspective.* Toronto: Harcourt Saunders.

Peter, E. & Morgan, K. (2001). Explorations of a trust approach for nursing ethics. *Nursing Inquiry, 8*(1), 3-10.

Varcoe, C. & Rodney, P. (2002). Constrained agency: The social structure of nurses' work. In B. S. Bolaria & H. Dickinson (Eds.), *Health, Illness and health care in Canada* (3rd ed., pp.102-128). Scarborough, ON: Nelson Thomas Learning.

Waters, W. F. (2001). Globalization, socioeconomic restructuring and community health. *Journal of Community Health, 26*(2), 79-92.

Webster, G. & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

White, G. (2001). The code of ethics for nurses: Responding to new challenges in a new century. *American Journal of Nursing, 101*(10), 73, 75.

Yeo, M. & Moorhouse, A. (Eds.). (1996). *Concepts and cases in nursing ethics* (2nd ed.). Peterborough, ON: Broadview Press.

Web Sites for International Documents on Human Rights

Numerous documents can be found on web sites. For example, the *Universal Declaration on Human Rights, Article 25; International Convenant on Economic, Social and Cultural Rights, Article 12; International Convention on Elimination of all Forms of Racial Discrimination; Convention on Elimination of all Forms of Discrimination Against Women; Convention on the Rights of the Child; Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; UN Resolution 46/119 Protection of Persons with Mental Illness and Improvement of Mental Health Care; World Health Organization Constitution.*

http://www.un.org/rights

http://www.who.int/archives/who50/en/human.htm

http://www.unesco.org/ibc/index.html

APPENDIX I

INTERNATIONAL COUNCIL OF NURSES CODE

OF ETHICS FOR REGISTERED NURSES

----- Original Message -----
From: turin@icn.ch
To: bbygirl2@maxxconnect.net
Sent: Friday, October 24, 2003 12:09 AM
Subject: RE: Request for Instructions on obtaining Permission

Good morning,

ICN is very pleased to grant you permission to include the ICN Code of Ethics on your thesis "Ethics in the Clinical Setting".

We ask that the ICN copyright and corporate identification logo appear on the final documents. The correct copyright text is as follows:

Copyright © 2000 by ICN - International Council of Nurses,
3, place Jean-Marteau, 1201 Geneva (Switzerland)

The logo can be downloaded from our website http://www.icn.ch/icncode.pdf

All the very best to you

Warmest regards,

Danielle Turin, Assistant
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Tel.: +41 22 908 01 00
Fax: + 41 22 908 01 01
Email: turin@icn.ch

The International Council of Nurses is a federation of 125 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

Wear the "White Heart" pin, symbol for Nursing

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The ICN CODE OF ETHICS

FOR NURSES

The ICN Code of Ethics for Nurses

An international code of ethics for nurses was first adopted by the International Council of Nurses (ICN) in 1953. It has been revised and reaffirmed at various times since, most recently with this review and revision completed in 2000. The ICN Code of Ethics is also available in French [pdf file] Spanish [pdf file] German.

Preamble

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal.

Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect. Nursing care is unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, nationality, politics, race or social status.

Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups.

THE CODE

The *ICN Code of Ethics for Nurses* has four principal elements that outline the standards of ethical conduct.

Elements of the Code

1. Nurses and people

The nurse's primary professional responsibility is to people requiring nursing care.

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse holds in confidence personal information and uses judgement in sharing this information.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2. Nurses and practice

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.

The nurse maintains a standard of personal health such that the ability to provide care is not compromised.

The nurse uses judgement regarding individual competence when accepting and delegating responsibility.

The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.

The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.

3. Nurses and the profession

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.

The nurse is active in developing a core of research-based professional knowledge.

The nurse, acting through the professional organisation, participates in creating and maintaining equitable social and economic working conditions in nursing.

4. Nurses and co-workers

The nurse sustains a co-operative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard individuals when their care is endangered by a co-worker or any other person.

Suggestions for use of the ICN Code of Ethics for Nurses

The *ICN Code of Ethics for Nurses* is a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society.

To achieve its purpose the *Code* must be understood, internalised and used by nurses in all aspects of their work. It must be available to students and nurses throughout their study and work lives.

Applying the Elements of the ICN Code of Ethics for Nurses

The four elements of the *ICN Code of Ethics for Nurses*: nurses and people, nurses and practice, nurses and co-workers, and nurses and the profession, give a framework for the standards of conduct. The following chart will assist nurses to translate the standards into action. Nurses and nursing students can therefore:

- Study the standards under each element of the *Code*.
- Reflect on what each standard means to you. Think about how you can apply ethics in your nursing domain: practice, education, research or management.
- Discuss the *Code* with co-workers and others.
- Use a specific example from experience to identify ethical dilemmas and standards of conduct as outlined in the *Code*. Identify how you would resolve the dilemma.
- Work in groups to clarify ethical decision making and reach a consensus on standards of ethical conduct.
- Collaborate with your national nurses' association, co-workers, and others in the continuous application of ethical standards in nursing practice, education, management and research.

Element of the Code # 1: NURSES AND PEOPLE		
Practitioners and Managers	**Educators and Researchers**	**National Nurses' Associations**
Provide care that respects human rights and is sensitive to the values, customs and beliefs of people.	In curriculum include references to human rights, equity, justice, solidarity as the basis for access to care.	Develop position statements and guidelines that support human rights and ethical standards.
Provide continuing education in ethical issues.	Provide teaching and learning opportunities for ethical issues and decision making.	Lobby for involvement of nurses in ethics review committees.
Provide sufficient information to permit informed consent and the right to choose or refuse treatment.	Provide teaching/learning opportunities related to informed consent.	Provide guidelines, position statements and continuing education related to informed consent.
Use recording and information management systems that ensure confidentiality.	Introduce into curriculum concepts of privacy and confidentiality.	Incorporate issues of confidentiality and privacy into a national code of ethics for nurses.
Develop and monitor environmental safety in the workplace.	Sensitise students to the importance of social action in current concerns.	Advocate for safe and healthy environment.

Element of the Code # 2: NURSES AND PRACTICE		
Practitioners and Managers	**Educators and Researchers**	**National Nurses' Associations**
Establish standards of care and a work setting that promotes quality care.	Provide teaching/learning opportunities that foster life long learning and competence for practice.	Provide access to continuing education, through journals, conferences, distance education, etc.
Establish systems for professional appraisal, continuing education and systematic renewal of licensure to practice.	Conduct and disseminate research that shows links between continual learning and competence to practice.	Lobby to ensure continuing education opportunities and quality care standards.
Monitor and promote the personal health of nursing staff in relation to their competence for practice.	Promote the importance of personal health and illustrate its relation to other values.	Promote healthy lifestyles for nursing professionals. Lobby for healthy workplaces and services for nurses.

Element of the Code # 3: NURSES AND THE PROFESSION		
Practitioners and Managers	**Educators and Researchers**	**National Nurses' Associations**
Set standards for nursing practice, research, education and management.	Provide teaching/learning opportunities in setting standards for nursing practice, research, education and management.	Collaborate with others to set standards for nursing education, practice, research and management.
Foster workplace support of the conduct, dissemination and utilisation of research related to nursing and health.	Conduct, disseminate and utilize research to advance the nursing profession.	Develop position statements, guidelines and standards related to nursing research.
Promote participation in national nurses' associations so as to create favourable socio-economic conditions for nurses.	Sensitise learners to the importance of professional nursing associations.	Lobby for fair social and economic working conditions in nursing. Develop position statements and guidelines in workplace issues.

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Element of the Code #4: NURSES AND CO-WORKERS		
Practitioners and Managers	**Educators and Researchers**	**National Nurses' Associations**
Create awareness of specific and overlapping functions and the potential for interdisciplinary tensions.	Develop understanding of the roles of other workers.	Stimulate co-operation with other related disciplines.
Develop workplace systems that support common professional ethical values and behaviour.	Communicate nursing ethics to other professions.	Develop awareness of ethical issues of other professions.
Develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel.	Instil in learners the need to safeguard the individual, family or community when care is endangered by health care personnel.	Provide guidelines, position statements and discussion for a related to safeguarding people when their care is endangered by health care personnel.

Dissemination of the ICN Code of Ethics for Nurses

To be effective the ICN Code of Ethics for Nurses must be familiar to nurses. We encourage you to help with its dissemination to schools of nursing, practising nurses, the nursing press and other mass media. The Code should also be disseminated to other health professions, the general public, consumer and policy making groups, human rights organisations and employers of nurses.

Glossary of terms used in the ICN Code of Ethics for Nurses

Co-operative relationship	A professional relationship based on collegial and reciprocal actions, and behaviour that aim to achieve certain goals.
Co-worker	Other nurses and other health and non-health related workers and professionals.
Nurse shares with society	A nurse, as a health professional and a citizen, initiates and supports appropriate action to meet the health and social needs of the public.
Personal health	Mental, physical, social and spiritual well -being of the nurse.
Personal information	Information obtained during professional contact that is private to an individual or family, and which, when disclosed, may violate the right to privacy, cause inconvenience, embarrassment, or harm to the individual or family.

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Related groups   Other nurses, health care workers or other professionals
                                      providing service to an individual, family or community
                                      and working toward desired goals.

REFERENCES

Aiken, T. D., & Catalano, J. T. (1994). *Legal, ethical, and political issues in nursing*. Philadelphia: F. A. Davis Company.

American Nurses Association. (1985). Code of ethics. *American Nurses Association, 7*(3), 7, 262.

American Nurses Association. (2001). *Code of Ethics for Nurses with Interpretive Statements*, Reprinted with permission from the American Nurses Association, Washington, DC. http://www.ana.org/ethics/chcode.htm

Aroskar, M. A. (1986). Are nurses' mind sets compatible with practice? In P.L. Chinn, *Ethical issues in nursing* (pp. 69-79). Rockville, MD: Aspen.

Bandman, E., & Bandman, B. (2002). *Nursing ethics through the life span* (4th ed.). Upper Saddle River, NJ: Prentice Hall.

Beauchamp, T. L., (1994). *Principles of biomedical ethics*. New York: Oxford University Press.

Canadian Nurses Association. (1991). *Canadian Nurses Association Code of Ethics for Nursing*. Ottawa, Ontario: Canadian Nurses Association.

Canadian Nurses Association. (2002). *Code of Ethics for Nursing*. Reprinted with permission from the Canadian Nurses Association: Washington, DC http://www.can-aiic.ca

Catalano, J. T. (1995). *Ethical and legal aspects of nursing* (2nd ed.). Springhouse, PA: Springhouse Corporation.

Christopher, J. (1999). Unravelling the dilemmas within everyday nursing practice. *Nursing Ethics, 6*(4), 287.

Cragg, C. E. (1988). Nursing ethics: Essential component of continuing education. *The Journal of Continuing Education in Nursing, 19*, 266-269.

Dinc, L., & Gorgulu, R. S. (2002). Teaching ethics in nursing. *Nursing Ethics, 9*(3), 259.

Glatthorn, A. (1987). Cooperative professional development: Peer-Centered options for teacher growth. *Educational Leadership, 44*, 31-33.

Guido, G. W. (2001). *Legal and ethical issues in nursing* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Hein, E. C. (2001). *Nursing issues in the 21st century: Perspectives from the literature.* Philadelphia: Lippincott.

Holland, S. (1999). Teaching nursing ethics by cases: A personal perspective. *Nursing Ethics, 6*(5), 434.

International Council of Nurses. (2000). *Code of Ethics for Nurses.* Reprinted with permission from the International Council of Nurses: Geneva, Switzerland. http://www.icn.ch/icncode.pdf

Josephson Institute of Ethics. (2003). *Character Counts-Pursing Victory with Honor.* Santa Monica, CA: Josephson Institute.

Kohn, L. T. (1997). *Methods in Case Study Analysis Technical publication #2.* Retrieved October 16, 2003 from http://www.hschange.com/CONTENT/158/158.pdf

Nilstun, T., Cuttini, M., & Saracci, R. (2001). Teaching and learning medical ethics: Teaching medical ethics to experienced staff. *Journal of Medical Ethics, 27*(6), 409.

Notter, L. E., & Spalding, E. K. (1976). *Professional Nursing: Foundations, perspectives and relationships* (9th ed.). Philadelphia: J. B. Lippincott Company.

O'Neil, J. A. (1991). *Journal of Continuing Education in Nursing, 22*(5), 184-185.

Ornstein, A. C., & Hunkins, F. P. (1998). *Curriculum foundations, principles, and issues* (3rd ed.). Needham Heights, MA: Allyn and Bacon.

Redman, R. W., Lenburg, C. B., & Walker, P. H. (1999). Competency Assessment: Methods for development and implementation in nursing education. *Online journal of issues in nursing.* Retrieved October 9, 2003 from http://www.nursingworld.org/ojin/topic10/tpc10_3.htm

Reed, A. J. S., Bergemann, V. E., & Olson, M. W. (1998). *In the classroom: An introduction to education* (3rd ed.). Boston: The McGraw-Hill Companies, Inc.

Rosenholtz, S. (1989). *Teacher's Workplace: The Social Organization of Schools.* New York: Longman.

Scanlon, C. (2000). A professional code of ethics provides guidance for generic nursing practice. *Nursing Ethics, 7*(3), 7, 262.

Slavin, R. E. (1997). *Educational Psychology-Theory and Practice* (5th Ed.). Needham Heights, MA: Allyn & Bacon.

Taba, H. (1962). *Curriculum Development Theory and Practice.* International Thomson Publishing

Taylor, C., Lillis, C., & LeMone, P. (1997). *Fund amentals of nursing* (3rd ed.). Philadelphia: Lippincott-Raven Publishers.

Tyler, R. W. (1949). *Basic Principles of Curriculum and Instruction.* Chicago: The University of Chicago Press.

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