

Practical Use of the Nursing Code of Ethics: Part I

A code of ethics is a fundamental document for any profession. It provides a social contract with the society served, as well as ethical and legal guidance to all members of the profession. The focus of this article is on the assistance provided to the clinical nurse by the *Code of Ethics for Nurses with Interpretative Statements* (The Code) (American Nurses Association [ANA], 2001) as he or she functions in progressively more complex roles and situations. Part I of this series will focus on the first four of the nine provisions. Later this year, Part II will focus on the remaining provisions.

Since the original ANA Code in 1950, the central significance of service to others has been consistent (Fowler, 2008). Two significant conceptual changes have occurred in The Code since this inception. First, the patient is not considered as an individual receiving treatment, but also his or her family and the community in which they live are considered. Second, the fifth provision prompts nurses to recognize, "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" (ANA, 2001, p. 18). The present Code informs nurses, patients, and the public on the core values of nursing.

Fowler (2008) provided nurses with a book that helps interpret and apply the provisions of The Code to everyday practice of nursing. The case examples encourage self-reflection on the ethical obligations of the nurse. Each provision is discussed by a renowned nurse ethicist who incorporates the ethical principles supporting the provision. This book is recommended for a more in-depth examination of the issues discussed in this article.

Understanding the Essence of Code Provisions

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 econom-*

ic status, personal attributes or the nature of health problems (ANA, 2001, p. 7).

First, the nurse is expected to practice kindness and respect, regardless of who is receiving his or her communication. This receiver could be a respiratory therapist, nursing assistant, or patient who has been unwilling to take prescribed medications or follow treatment recommendations consistently. Even though most nurses are quick to say they entered the profession to help others, few will admit to prejudice toward helping "certain people." While the nurse need not feel warmth toward all humanity, he or she is expected to not let feelings of anger or disgust justify uncaring behavior. As a professional, the nurse is expected to reflect and move beyond feelings to provide the same level of care to every patient, regardless of diagnosis, skin color, ethnic origin, or economic status.

The therapeutic use of self is expected in this provision. In every human interaction, we communicate one of three statements:

1. Go away, my world would be better without you.
2. You are an object, a task to be done, you mean nothing to me.
3. You are a person of worth, I care about you (Fowler, 2008, p. 6).

What do a nurse's touch, look, and actions communicate? Do they convey respect for the person receiving care?

In the field of bioethics, the principle of autonomy is central. *Autonomy* often replaces *respect for persons* in ethics discussions. Autonomy is exemplified in this provision as the right to self-determination. Too often, for example, a nurse may believe the only obligation in procedure/surgical informed consent is to witness the form. However, to support the patient's autonomous right, the provision indicates that the nurse must be mindful of the following:

"Patients have a 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” (ANA, 2001, p. 8).

This support may involve calling a physician to come and re-explain the procedure, or assuring the surrogate who signed the consent has the best interest of the patient in mind. This support of patient autonomy also may include “recognition that people of some cultures place less weight on individualism and choose to defer to family...” (ANA, 2001, p. 9). The nurse’s responsibility is to guarantee that the patient is comfortable in handing over decision making to another. The nurse needs to assure that the family has not taken the patient’s right to choice without his or her consent.

This surrogate decision making is important, especially in the vulnerable population of dying patients. “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” (ANA, 2001, p. 8). The nurse must advocate for the patient to receive palliative care when the goals of care change from cure to comfort. He or she may need to bolster the family’s decision to move the patient into hospice care, or request an ethics consult if the patient’s advance directive wishes are being violated by family and/or physicians.

This provision also addresses the importance of relationships with colleagues and others. Every time nurses “eat our young;” engage in lateral violence, harassment or threatening behavior; or disregard our effect on another, we violate The Code. Because the provision of safe, quality care requires the interdisciplinary collaboration of all, respect for *all* is the hallmark of this provision.

Provision 2. *The nurse’s primary commitment is to the patient, whether an individual, family, group, or community* (ANA, 2001, p. 9).

The nurse may experience a conflict in his or her dual obligation to the organization and to the patient. Ethical dilemmas will arise as the nurse attempts to balance a commitment to the patient, the family, and the community. However, The Code is clear that the primary obligation is to the patient. Business priorities may be pressing in the organization, and powerful enough to cause conflict of interests. “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” (ANA, 2001, p. 10). To do this may require the virtue of courage; speaking the truth based on understanding the ethical principles of veracity (truth telling), fidelity (keeping promises), and nonmaleficence (do no harm) (Beauchamp & Childress, 2001).

When the community is the patient and resources are limited, the ethical issue of distributive justice (fairness of how resources are distributed) is prominent. In the case of an epidemic, autonomy of individuals often is outweighed by the health and welfare of

the many others. Fair and equitable distribution of resources requires patient triage to determine the most likely to survive. Such distribution is based on utilitarianism (the greatest good for the greatest number) (Beauchamp & Childress, 2001). “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 to preserve the rights of others and the demands of justice” (ANA, 2001, p. 9).

The second provision also clearly describes the importance of collaboration in caring for a patient in the complex environment of health care. The nurse plays a central role in creating an environment of mutual trust and respect among all health care professionals by engaging in an open dialogue and claiming a place in the shared decision making about patient care. The nurse must not only lay claim to the collaborative, interdisciplinary care planning meetings, but also to his or her place at the table in administration of the enterprise to assure quality care.

Professional boundaries are the last issue discussed in the second provision. By the very nature of nursing, closeness occurs between nurse and patient in the physical, emotional, and spiritual realms. Blurring of these boundaries is more likely in long-term relationships found in psychiatry and rehabilitation. However, multiple admissions of a patient with chronic disorders is likely to lead the medical-surgical nurse to develop a significant relationship with this person. The purpose of this relationship is not friendship but “...alleviating suffering, and protecting, promoting, and restoring the health of patients” (ANA, 2001, p. 11). In all encounters, regardless of the patient’s behavior, the nurse has the obligation to maintain professional boundaries.

Provision 3. *The nurse promotes, advocates for, and strives to protect the health, safety and rights of the patient* (ANA, 2001, p. 12).

The first two parts of this provision focus on the patient’s right to privacy; the individual has a right to have known only what he or she chooses to reveal. The nurse has an obligation to safeguard a patient’s privacy. “Only information pertinent to a patient’s treatment and welfare is disclosed, and only to those directly involved with the patient’s care” (ANA, 2001, p. 12). The complexity of confidentiality was highlighted by the implementation of the Health Information Portability and Accountability Act (HIPAA) (Artnak & Benson, 2003). HIPAA, like The Code, is designed to provide guidance to the nurse, not absolutes. The nurse thus must balance the patient’s right to privacy with protection of the patient from harm.

Obligation for confidentiality is not unconditional and can be adapted to protect the patient and innocent parties, and in cases of mandatory reporting for public health reasons. For example, a patient may swear a nurse to secrecy when he or she indicates, “I do not want this surgery tomorrow. I have lived a good life and I am ready to die, but my children have pressured me endlessly to go ahead with the surgery.” If the nurse maintains this privacy, however, a surgical

procedure will occur on a patient who was coerced into it by family. This violates the voluntary nature of consent, one of the key tenets of informed consent. Another example is the duty to warn a third party if the nurse is told that an individual plans to harm a particular person. Finally, the nurse is mandated to report child abuse and (in some states) elder abuse, as well as tuberculosis as a communicable disease.

The third provision also focuses on safeguarding research participants. The first part discusses the need for effective informed consent, while the second part identifies the need to assure that the research is performed by a competent person. "Nurses have a duty to question and, if necessary, to report and to refuse to participate in research they deem morally objectionable" (ANA, 2001, p. 13).

The last three sections of the third provision deal with the problem of incompetent practice. "The nurse has a responsibility to implement and maintain standards of professional nursing practice" (ANA, 2001, p. 13). Whether the incompetence is due to impairment, or lack of knowledge or skill, the nurse must report the deficit to the appropriate person in the organizational hierarchy. If no action is taken on this incompetence, the nurse demonstrates responsibility for the health and safety of patients in the organization by going to the next step in the hierarchy, or if necessary to an outside accrediting or legislative body. The statement, "I reported the problem to my manager and it is not my problem if it continues," is not defensible in a court of law; it also represents a violation of The Code. Unfortunately, even with organizational and governmental regulation protection, reporting unethical, illegal, incompetent, or impaired practice may leave the nurse with serious harm (Lachman, 2008). However, this threat of harm does not remove the requirement to convey critical threats to patient safety to appropriate authorities.

Because impairment due to addiction or mental illness is a treatable condition, the nurse also has the obligation to advocate for treatment for the affected colleague and welcome the recovering nurse back to practice. Too often, a nurse may turn a blind eye to the problem of impairment and then fail to provide a supportive environment when the colleague demonstrates the courage to return to practice. According to The Code (ANA, 2001), the nurse is obligated to protect patients and advocate for colleagues.

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* (ANA, 2001, p. 16).

The recognition of accountability for actions is the cornerstone for a profession because of the implied social contract with the public. "Accountability means to be answerable to oneself and others for one's own actions" (ANA, 2001, p. 16). Nursing has been identified repeatedly as the most trusted profession because its practitioners take seriously their accountability to the patient and the public (Saad, 2008).

What does this accountability include? A nurse is responsible for assessing the role demands and determining if he or she has the knowledge, competence, and experience to engage safely in the required action. The professional nurse is expected to seek educational resources when he or she is not competent to perform a task. According to The Code (ANA, 2001), the nurse is obligated to seek the necessary help to make appropriate nursing judgments.

Equally important, the nurse is accountable for the assignment of nursing responsibilities to other nurses and delegation of nursing activities to other health care providers. "Delegation is the process for the nurse to direct another person to perform nursing tasks and activities" (ANA & National Council of State Boards of Nursing, 2006). "Nurses may not delegate responsibilities such as assessment and evaluation; they delegate tasks" (ANA, 2001, p. 17). For example, the nurse can delegate an intervention to increase a patient's mobility, but not the evaluation of the intervention in achieving the desired outcome. A nurse also has the responsibility to assess the competence of the person receiving delegation, and to monitor and evaluate the delegate's results.

Summary

The Code (ANA, 2001) provides the nurse guidance for legal and ethical responsibilities to patients and, in the broader sense, to society. The first provision calls for honoring the human dignity in all patients and colleagues. It lays the groundwork for the importance of the essential ethical principle of autonomy, the right to self-determination. The second provision describes the importance of interdisciplinary collaboration and significance of appropriate nurse-patient boundaries. The importance of privacy and confidentiality in the nurse-patient relationship is the focus of the third provision. Without the nurse's honoring of privacy, the patient would be hesitant to share important information necessary to design an effective plan of care. The fourth provision primarily focuses on the importance of accountability for personal actions and for the actions of those to whom the nurse has delegated. By meeting these obligations, the nurse will remain the most trusted health care professional. ■

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