

Practical Use of the Nursing Code of Ethics: Part II

In the January/February 2009 issue of *MEDSURG Nursing*, I discussed the first four provisions of the *Code of Ethics for Nurses with Interpretative Statements* (The Code) (American Nurses Association [ANA], 2001). In this column, I will continue this practical discussion on the remaining five provisions. The goal of this article is to provide the clinical nurse with practical application of each of these provisions.

Understanding the Essence of Code Provisions

Provision V. *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).

First, this provision addresses the idea that nurses owe to themselves the same moral duties they owe others. Self-respect, or seeing the self as deserving of worth, is the foundation of this fifth provision. As Mark Twain said, "The worst loneliness is to not be comfortable with yourself" (Wisdom Quotes, 2009). Self-respect is fundamental for a happy life. A person who lacks self-respect will be insecure and strive to be someone he or she is not (Pettinger, 2008). The Roland and Foxx (2003) model of self-respect prominently includes such components as independence, tenacity, and dignity. In this model, the sources and constituents of self-respect basically are *internal* to the actor. Roland and Foxx treat self-respect as a form of self-evaluation that depends on commitment to moral ideals and on living up to personal principles. Acting courageously probably assumes some nominal level of self-esteem, and having acted courageously is even more likely to promote increased self-respect. Without this self-respect, nurses may not have the moral courage to act to protect others.

Humility involves having a proper assessment of personal worth. In any case, overestimation of self-worth is clearly an important moral phenomenon as

traditional accounts of humility emphasize, but so too is underestimation of self-worth. In fact, most people have the tendency to underestimate rather than overestimate their value. To prevent this underestimation, this provision encourages nurses to include professional growth and maintenance of competence, wholeness of character, and preservation of integrity.

Second, professional growth and maintenance of competence require continuous acquisition of knowledge and skills relevant to a chosen specialty. For medical-surgical nurses, the array of possible subjects is vast; therefore, unit specialties within medical-surgical services have emerged. Continued growth might include advanced degrees in medical-surgical nursing and certification (certified medical-surgical nurse [CMSRN]). *Scope and Standards of Medical-Surgical Nursing Practice* (Academy of Medical-Surgical Nurses, 2000) provides the medical-surgical nurse with the required current scope of practice and principles in the continuous learning realm of medical-surgical nurses.

Third, wholeness of character addresses the integration of personal and professional values. This assimilation is not possible without the open debate among professionals who encounter the application of evidence-based practice daily. Expert nurses bring years of clinical experience, but without the knowledge gained from education and reading, their care may reflect outdated practices. The treatment of decubitus ulcers comes to mind, where treatments vary from unit to unit; some treatments actually may make the problem worse (Reddy et al., 2008).

This wholeness of character often is reflected in the scenario in which the patient requests the opinion of the nurse. Though the professional nurse is free to express such an opinion, I as a nurse ethicist encourage the nurse to avoid doing so. Instead, assist "patients to clarify their own values in reaching informed decisions..." to avoid unintended persuasion (ANA, 2001, p. 19). The respectful and skilled care of a nurse in the typical stigmatized care situation (e.g., mental illness and AIDS) helps patients regain their self-respect.

Fourth, the preservation of integrity and moral self-respect encompasses the final aspect of provision

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five. Threats to nurses' integrity are numerous, and the present economic environment only increases the coercion. Nurses have the ethical obligation to disclose errors, and neither falsify records nor tolerate verbal abuse from health care workers of any status. This does rule out "integrity preserving compromise," where the dignity of the nurse and others is not compromised.

Preservation of nurses' integrity can be accomplished with an often underutilized concept known as "conscientious objection."

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 patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Such grounds exclude personal preference, prejudice, convenience or arbitrariness (ANA, 2001, p. 20).

Nurses can not abandon their patients and must provide other resources for the required nursing care. In situations where this is a repeated pattern, nurses must bring the situation to administrative levels. For example, nurses repeatedly are expected to practice in the unsafe environments of emergency rooms that refuse to go on divert when patient volume and acuity warrant such an action.

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 (ANA, 2001, p. 20).*

Where does nurses' obligation to excellent patient care stop? This is a question often asked by beginning and naive nurses. Many experienced nurses know their obligation extends to the need to change health care cultures that lead to poor patient care and patient dissatisfaction.

First, this provision discusses moral virtues and values. Aristotle was the first to discuss the importance of virtue development. He believed character also is the result of habit. If the individual repeatedly strives for excellence, this habit will yield an excellence of character. Aristotle believed that virtue of courage was the balance (mean) between extremes of cowardice and rashness. Therefore, a man might rush headfirst into danger either because he is blinded by rage (terrorist) or because he is oblivious (intoxication) to the hazards that lie ahead. According to Aristotle, courage is defined as having rational control of emotion and passion; the person is expected to have control over fear and other emotional states. He proposed that both deficiency and excess in a virtue could be catastrophic. Aristotle wrote, "He is courageous who endures and fears the right things, for the right motive, in the right manner, and at the right time and who displays confidence in a similar way" (NE III7.1115b15-20). He resolved that a virtue, like courage, only be used for honorable ends.

In this provision, both the influence of the environment on nurses (6.2) and nurses on the environment (6.3) are outlined. The obligation of nurses to affect the moral environment of the organization is clear. This is true not only through the nursing administration environment, but also through nurses' unwillingness to acquiesce and accept unsafe or inappropriate practices in the organizational culture. Nurses can not honor *The Code* and accept unsafe conditions that repeatedly compromise the standards of safe practice or personal morality.

The goal is for nurses to work with administration to create an environment for safe and quality patient care. However, when this is not possible, nurses are responsible to "participate in collective action such as collective bargaining or workplace advocacy, preferably through a professional association such as a state nurses association" (ANA, 2001, p. 21). Nurses may need to leave organizations that refuse to support patient rights or put nurses in a position that consistently demands violation of the professional standards of practice.

The professional association of nursing seeks to serve professional nurses in service of the patient. The collective bargaining agreements reached between professional nurses and the organization are focused on the well-being of both patients and nurses. In such cases, the professional association acts as the advocate for both.

Provision 7. *The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development (ANA, 2001, p. 22).*

To comply with this provision, clinical nurses meet the obligation to advance the nursing profession through an assortment of activities. Examples include mentorship, service on shared governance committees in the place of employment or in professional organizations, or leadership in their professional organization. All nurses, regardless of their positions, have an obligation to involve themselves in some civic activity on the local, national, or international level. For example, nurses may volunteer in a homeless shelter or as nurse practitioners in a Botswana village destroyed by AIDS. Nurse educators could develop a variety of service initiatives in long-term care, homeless shelters, or public schools.

Nurse educators are responsible for maintaining clear standards for nursing education. Nurse educators working on medical-surgical units are accountable to assure the orientation, preceptorship, and continuing education activities all promote an environment that supports professional practice. College professors have the responsibility to allow only those who meet the predetermined essential competencies to graduate from nursing programs.

Two professional nursing organizations focus on the importance of knowledge development, dissemination, and application to practice: National League for Nursing (NLN) and American Association of Colleges of Nursing (AACN). One goal of the NLN is to lead in setting standards that press forward excellence and inno-

vation in nursing education. With this goal in mind, the NLN has nine initiatives designed to create excellence and innovation in nursing education (NLN, 2009).

Recently, the AACN (2006) offered the option of a clinical doctorate to increase requirements in nursing education. AACN proposed that all advanced practice nurses be prepared with a doctor of nursing practice (DNP) by 2015. Practice doctorates are not a new phenomenon; such models exist in physical therapy, pharmacy, and psychology. For a more complete understanding of the history and reasoning behind the degree, see AACN's *Essentials of Doctoral Education for Advanced Nursing Practice* (2006), available on the association's Web site. In addition, these programs provide clinical nurses with the skills to take their rightful places as leaders of the interdisciplinary clinical team. A hybrid DNP program also can train nurses to take their places as primary investigators in research (Drexel University, 2005). Nurse researchers in hospitals seeking Magnet® designation provide the advice and support to clinical nurses seeking to provide practice-based evidence.

Nurse administrators could accomplish this provision by providing an employment environment that supports ethical integrity and empowerment opportunities. The scope and standards of all nursing disciplines can be found on the ANA Web site (www.nursesbooks.org). Nursing administrators must provide a professional climate where these standards are fully operational.

Provision 8. *The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs (ANA, 2001, p. 23).*

This provision addresses the macro level of responsibility professional nurses have in being aware of and involved in the "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" (ANA, 2001, p. 23). For example, the International Centre for Nursing Ethics (2008) human rights and nursing awards were given to Emmie Chanika (Malawi) and Sister Teresita Hinnegan (Philadelphia, PA). Emmie Chanika is a nurse and human rights lawyer, with particular concern for the rights of women and children, and the sale of body parts in her country. After a long career in nursing and midwifery, Sister Teresita Hinnegan has opened a safe house for abused women and founded an organization for the understanding and awareness of issues that lead to such situations.

Thousands of nurses win no awards for their dedication to migrant farm workers, individuals in refugee centers, or children in juvenile detention centers. These nurses educate the public on these vulnerable populations and identify conditions that lead to illness in these populations. They work endlessly to bring public awareness to the point of moral outrage in order to stimulate possible policy and legislative changes.

Finally, nurses must recognize cultural sensitivity

is necessary in our global village. Too often, ethnocentric views stop nurses from seeing *their* personal cultural or social groups have no superiority over those of a different race, economic status, or sexual orientation. Nurses have a professional obligation to recognize their prejudices and demonstrate respect for the values and practices of those from different cultures.

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 of social policy (ANA, 2001, p. 24).*

Since Florence Nightingale, nursing has been concerned about how society affects health and illness (Dossey, Selanders, Beck, & Attewell, 2004). This steadfast focus on social ethics is often a point of pride in the nursing profession. Nurses exercise this focus on social ethics most often through their collective voices in professional associations in nursing.

The integrity of the profession is maintained through the *Code of Ethics for Nurses*, the standards of nursing practice, educational requirements for practice, knowledge development, and continuous evaluation of professional nursing actions. Professional nursing associations have a responsibility to support these mechanisms of maintaining a profession. The reasonable self-interest concerns of the association and the profession are balanced by the commitment to the societal goods.

Social reform is spearheaded both by individuals and the collective action of nurses. Speaking about a health care policy and shaping policy for vulnerable individuals is the responsibility of the professional association. Another way to stimulate change is through political action committees (PACs). Professional associations can help change policies that violate the human rights of nurses and their patients. For example, individuals in a PAC typically demonstrate an interest in political activities; participation in political campaigns and/or political fundraising; lobbying at the local, state or national level; and regularly donating to the PAC.

Summary

The Code Provisions V through IX focus on a variety of responsibilities for the professional nurse. Provision V spotlights nurses' obligation to the same values and actions for themselves as are espoused in *The Code* for their patients. Provision VI addresses the responsibility of all nurses to maintain quality patient care, regardless of their roles in the health care system. Meeting professional obligations to maintain and forward the nursing profession can take a variety of forms, as indicated in Provision VII. Provision VIII reviews the macro level of professional nursing responsibility by centering on the issues of world hunger, pollution, and other violations of justice. Finally, Provision IX identifies the importance of involvement in professional associations and their efforts for social reform. The first two provisions of *The Code* address the boundaries of obligation and dependability (Lachman, 2009), and the last three address the duties outside individual patient experience. ■

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Additional Readings

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