The American Nurses Association is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent/state nurses associations and its organizational affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

Introduction.
Provisions, Decisions, and Cases: Getting to What is Right and Good

This book, *Guide to the Code of Ethics with Interpretive Statements: Development, Interpretation, and Application*, is intended to set the Code within its developmental context, provide resources that further the readers' understanding of the Code, identify pivotal documents that have and continue to inform nursing ethics, and to guide nurses in the application of the Code. An attempt has been made to provide all the information needed for a basic understanding of the Code, which includes both the provisions and interpretive statements. Each section of the interpretive statements is discussed in detail. Additional information, beyond the basics, is also provided in order to nurture curiosity and to provide a rich foundation that can challenge the reader to achieve a greater depth of understanding. Most of all, this material will foster a pride of profession of which nursing is eminently worthy.

The book consists of nine chapters, each corresponding to a provision of the Code. The introduction to each provision is intended to go beyond a mere notation of how previous Codes stated the provision. Instead, each provision is set within its developmental context by showing how it originated historically, and how and why it changed over the decades. The changes to each provision are also set within their social context in an attempt to demonstrate how society has influenced change in nursing and its codes, how nursing's own growth, interests, and ideals have interacted with society, and how both come together to influence the provisions of the Code. In some instances, the introduction also develops key concepts (e.g., compassion, human dignity) in the specific provision. The introductory material of each chapter is especially relevant when examining issues and trends in nursing or nursing and society and nursing history. The discussions under each interpretive statement are focused on how the provision should be interpreted and how it is to be applied in practice.

For each chapter, an attempt has been made to include ample citations for pivotal documents so that those who wish to go more deeply into their study

of specific issues will have an easy point of access. These citations include documents of historical importance, documents that are internationally binding or advisory, national regulatory documents, and nursing research articles that are of great significance or have had a great impact on nursing ethics. Where these documents are available in full text online, website links are included in the endnotes. The American Nurses Association has a wealth of information available online and these webpages have also been cited in the endnotes.

A number of the chapters have illustrative cases. These cases are intended for group discussion and personal reflection and are designed to provide an opportunity to explore the particular concepts or issues related to the specific provision. The cases are based on real situations but all identifying features have been substantially altered or removed entirely to preserve the anonymity of the individuals and institutions involved.

Conceptual models or theories in nursing govern the categories, concepts, and vocabulary of practice. Likewise, ethical theories and models of ethical decision-making govern the categories, concepts, and vocabulary of data and analysis of ethical issues in clinical practice. It is therefore difficult to specify the particular questions that should be asked of a specific case, as the nature of the ethical decision-making method used will determine how those questions are formulated. One model might ask "Is the patient autonomous?" while another might ask "Has care been received?" However, to facilitate discussion, a series of questions is given below. These questions may or may not reflect the reader's preferred ethical decision-making model.

The Nursing Process, Models of Ethical Decision-Making, and Using the Cases

There are a number of approaches that can be used to analyze ethical issues and cases in professional practice. It is useful to become familiar with and develop expertise in one approach, but at the same time, knowledge of varied approaches expands one's repertoire for addressing ethical issues. Three commonly used approaches are discussed below. These descriptions are extremely brief. Space and the purpose of this book do not permit a full analysis or evaluation of ethical decision-making models. For a more substantive discussion of each method identified below, and the controversies over models of decision-making, please refer to the original works as cited in the endnotes.

Using the Nursing Process in Clinical-Ethical Situations and Case Discussion

It is possible to reflect upon clinical–ethical situations by using the nursing process to frame a specific ethical theory.[3,4,5] The nursing process is not itself an ethical theory. It provides an organizing template expected in all nursing practice in accordance with the standards of practice and legal–regulatory requirements. Thus, nurses are expected to use the nursing process even when the clinical matter at hand is ethical in nature. In clinical ethics, the following steps of the nursing process remain the same but the content of the steps of the nursing process is modified to accommodate the preferred ethical theory used to guide data collection and ethical analysis.

Assessment/Data collection: What is happening? What sort of a problem is it: ethical, moral, practical, relational? Who are the people involved? Once an issue is identified as an ethical issue, collect the morally relevant data including both facts (e.g., about the patient's medical or health status, pain, suffering, treatments, uncertainties) and values (e.g., patient and family values, beliefs, preferences, concerns, disagreements). Data collection should also include the concerns, values, opinions, and preferences of relevant others, such as the healthcare team, other health professionals, and perhaps the patient's community of reference. The specific data that must be collected will depend upon the ethical theory or approach that one chooses.

Assessment/Analysis: Analyze the factual and values data that has been collected using an ethic of care, virtue theory, principles of biomedical ethics, or another ethical theory.

Diagnosis. Make a clinical judgment about the care context, ethos, and issues including points of agreement or tension, conflicts of obligations, or conflicts of values. The diagnosis should reflect the fuller patient context including the patient herself or himself, relational network, community of reference, healthcare team, consultants, institutional circumstances or constraints. More than one moral issue may surface.

Outcomes/Planning. Ask "What would happen if…?" This is where the different approaches to ethics can be looked at and tried out. Based on the assessment and diagnosis, and in collaboration with the patient (and other health professionals as indicated), identify a range of approaches, or the best available approach when the possibilities are less than optimal. Some plans will include patient, family, and institutional interventions.

Implementation. What is the fitting answer? Ensure that it is the fitting answer, that is, one that is suitable and appropriate. A fitting answer

should also be right, but not all right answers are appropriate or fitting in a particular context. What is the outcome people can live with? Implement the plan in collaboration with the patient, family, and other health professionals.

Evaluation. What has happened? What can be learned from this situation? Both the patient's status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.

Sample Models of Ethical Decision-Making in Clinical Practice

These four models discussed below demonstrate different but widely accepted approaches to ethical analysis and decision-making in a range of professional practice roles and settings.

Jonsen's "Four Boxes"

Jonsen, Siegler, and Winslade have developed a useful means of evaluating moral dilemmas in clinical medical practice. Their approach has four domains or topics, often referred to as "the four boxes" because they are commonly arranged on a grid. The four domains are: medical indications, patient references, quality of life, and contextual features. This approach is heavily influenced by ethical principlism, that is, the use of the principles articulated by Beauchamp and Childress in their work *Principles of Biomedical Ethics.*[6] These principles are also articulated in *The Belmont Report* that governs the protection of human subjects in biomedical and behavioral research.[7] Jonsen, Siegler, and Winslade explain the four topics:

Our four topics or boxes provide a similar pattern for collecting, sorting, and ordering the facts of a clinical ethical problem. Each topic or "box" is filled with the actual facts of the clinical case that are relevant to the identification of the ethical problem, and the contents of all four are viewed together for a comprehensive picture of the ethical dimensions of the case.

Medical indications refer to the diagnostic and therapeutic interventions that are being used to evaluate and treat the medical problem in the case. Patient preferences state the express choices of the patient about their treatment, or the decisions of those who are authorized to speak for the patient when the patient is incapable of doing so. Quality of life describes features of the patient's life prior to and following treatment, insofar as these features are pertinent to medical decisions. Contextual features identify the familial, social, institutional, financial, and legal settings within which the particular case takes place, insofar as they influence medical decisions.[8] [italics original]

Summary of the Four Boxes[9]

Medical Indications	Patient References
Principles of Nonmaleficence and Beneficence *Data examples:* diagnosis, treatment, prognosis, acuity, chronicity, reversibility, terminality, goals of treatment, treatments that are not indicated, probability of success, benefit to the patient	**Principle of Respect for Autonomy** *Data examples:* patient informedness, comprehension, voluntariness, free consent, mental capacity, legal status, advance directive and/or prior expressed preferences, surrogate, cooperation

Quality of Life	Contextual Features
Principles of Nonmaleficence, Beneficence, and Respect for Autonomy *Data examples:* patient prospects of returning to normal life, deficits that might be predicted, what the patient desires in terms of quality of life, whether quality of life can be improved, under what conditions should treatment be stopped	**Principles of Justice and Fairness** *Data examples*: risks of professional or institutional conflicts of interest, vested interests, financial factors, institutional/social scarcity of resources, potential legal issues, public safety issues

Note that because the four boxes approach relies upon principles of ethics for data collection and analysis, many of the questions asked in ethical principlism will also be asked in this model as well.

Ethical Principlism

Ethical principlism is currently the dominant approach to ethical decision-making in clinical and research practice. Beauchamp and Childress discuss four bioethical principles in their landmark book *Principles of Biomedical Ethics*. These principles (respect for autonomy, nonmaleficence, beneficence, and justice) are held to be abstract, universal, value-neutral ethical principles that are used as tools to analyze moral dilemmas and issues and to specify ethical obligations. In practice, the first three principles are the "bedside" principles while justice is more often used at the societal or macro-level. Beauchamp and Childress maintain that these "pivotal moral principles…function as an

analytical framework of general norms derived from the common morality that form a suitable starting point for biomedical ethics. These principles are general guidelines for the formulation of more specific rules."[10] These principles and their subsidiary rules give rise to specific points of analysis. For example, the principle of respect for autonomy and its rule of informedness and voluntariness give rise to the following questions (not an exhaustive list):

- Is the patient autonomous?
- Is the patient's autonomy stable or fluctuating?
- Has autonomy been assessed on a renewing basis?
- Is the patient legally autonomous?
- Has the patient been informed?
- Has the patient waived informedness?
- Has the patient been given adequate, complete, and truthful information relevant to their situation?
- Does the patient have the capacity to understand the information?
- Has the patient understood the information?
- Does the patient have internal or external constraints to voluntariness?
- Can any constraints be ameliorated?
- Has the patient been unduly influenced?
- Has the patient given free consent?
- Has the consent fluctuated?

These questions, and those related to the other principles, form the basis of data collection for ethical decision-making. Each of the four principles and their subsidiary rules give rise to a set of questions that can be used to guide data collection and analysis in order to arrive at a specification of duty. The principles do not specify precisely how that duty will be met (e.g., whether the patient is given information by the physician or by the nurse), as there may be more than one way to meet that duty.

An Ethic of Care

While Jonsen, Siegler, and Winslade's four boxes model overlaps with Beauchamp and Childress's ethical principlism, an ethic of care approach is often seen to overlap with virtue ethics. Gastmans maintains that care is a virtue, but that an ethic of care is not virtue ethics.[11] In an ethic of care, "caring always takes place within the framework of a relationship where the caregiver

and the care receiver are reciprocally involved…the caregiver and care receiver give care together…. Care can only be considered 'completed' if the care offered is affirmed."[12] Care is set within the larger framework of societal expectations, institutional facilitators or hindrances, health professionals, relatives, the patient; all of these together constitute the healthcare team. Tronto identifies four phases of caring, each having a related moral element. The four phases are: caring about, taking care of, care giving, and care receiving. The four moral elements of an ethic of care are: attentiveness, responsibility, competence, and responsiveness.[13] Each of these phases and moral elements must be present for care to be demonstrated.

Four phases of caring	Four moral elements
Caring about	Attentiveness
Taking care of	Responsibility
Care giving	Competence
Care receiving	Responsiveness

In the first phase, the nurse must be attentive to needs within relationships, including all of the relationships surrounding the patient—nurse, family, health professions, institution, and societal expectations for care. The nurse must "pay attention to all relevant clinical factors involved, such as the patients' expectations, pains, fears, etc., as well as the professional and personal experiences of the caregivers."[14] These include questions of vulnerability, dignity, and meaningfulness. Patient wishes are focused within the relational identity of the patient and family, not in isolation. All their different viewpoints must be interpreted. Taking care of requires taking responsibility for each of the needs that have been observed, not as a set of principles of obligation, but as a situated ethics. An ethic of care emphasizes responsibility *to* people, not responsibility *for* another person. In care giving, the nurse acts upon those responsibilities, exercising the requisite knowledge, skill, and wisdom, that is, competence. In the care receiving phase, the patient or family affirms that care has been received. Only by virtue of this patient acknowledgement does it become clear that care has taken place. Without patient responsiveness there is no measure by which nurses can know that they and the patient shared in the identification and care of the same need.

A Brief Note on the Decision-Making Controversy

One of the main controversies in nursing over ethical decision-making models is the disagreement between advocates of an ethic of care and those who advocate ethical principlism. An ethic of care is understood by its proponents to address several issues that render ethical principlism less satisfactory for ethical decision-making in nursing. These theorists note that there are several difficulties with the principle-based ethics that dominates bioethical discourse, particularly in the form of Beauchamp and Childress's four principles and the "universal ethical principles" of Kohlberg (see Chapter 2). First, the principles themselves are mid-range and do not have a theory of ethics behind them that binds them together and makes them cohere. There is no common agreement on foundational principles as opposed to secondary principles, and some disagreement on which principles are morally relevant. Second, when principles conflict there is no theory or standard that guides arbitrating the conflict. Third, these abstract principles are described as universal, and value-neutral, but there is argument that the principles are rooted in the cultural values from which they arose. Callahan notes the strengths of principlism: "Taken in its own terms, principlism has two key virtues: it reflects the liberal, individualist culture from which it emerged, and is thus culture congenial; and it is relatively simple in its conceptualisation and application, and thus particularly attractive to clinical decision making."[15]

Thus, the very strength of principlism is at the same time its critique. Callahan sees two important failings of principlism: "For me, however, two problems have stood in the way of any enthusiastic embrace: its individualistic bias, and its capacity to block substantive ethical inquiry."[16] Another critique of ethical principlism is that it decontextualizes clinical decision-making and by doing so fails to take account of the morally relevant attributes of the case. An ethic of care is focused on clinical practice, especially on the relational context of care. This includes but is not limited to the nurse–patient relationship. It extends to all parties involved, plus the surrounding institutional environment and societal expectations for the nature of care.

Critics of an ethic of care argue that it is unclear whether care is an obligation, a virtue, or an end that is sought. They also argue that aspects of an ethic of care are vague and that decision-making must also utilize principles.

The reader is directed to the literature on models of decision-making to examine a fuller range of models, as well as exploring the controversies that exist over method.

Suggested Questions for Case Discussions

Is this an ethical or moral issue? The following questions are provided to facilitate classroom discussion or personal reflection upon the cases in each of the chapters. As noted above, these questions may or may not reflect the reader's preferred ethical decision-making model.

- What are the values, virtues, or obligations at stake in this case?
- What values, virtues, or obligations should be affirmed and why?
- How would you assess this situation morally?
- What are the clinical and medical dimensions of this situation?
- What are the patient's needs or desires?
- What are the needs or desires of others involved?
- What relationships are affected in this situation?
- What institutional factors affect this situation?
- What principles or rules are in conflict?
- What values are in conflict?
- What elements of the Code pertain?
- How might the Code inform your analysis or decision?
- If you were that nurse, how would you reason, ethically, about this?
- What arguments would you make for your position?
- What do you believe to be the strongest argument?
- In your ethical analysis, what would be acceptable options for action?
- What would not be acceptable options?
- What choice of action might promote the most good while causing the least harm?
- What actions might best affirm the relationships that exist?
- How might that be done?
- What are the ethical responsibilities of each of those involved?

Concluding Remarks

The ANA *Code of Ethics for Nurses with Interpretive Statements* continues to be the foundational moral document of American nursing. It encompasses the profession's values, obligations, ethical standards, aspirations, and ideals. The Code is also responsive to new issues or concerns that arise. New issues are neither morally disruptive nor morally innovative, nor beyond the compass of the Code. Because it is an expression of the values of the profession, the Code is capable of being extended to address new, unexpected issues. The Code is intended to guide nurses now and for the near future as they respond to the present and changing health and nursing needs of patients and populations. Through this 2015 revision and the revisions in the future, the Code is and will always be an enduring statement of the ethical core of nursing.

ENDNOTES

[1] Internal communiqué, American Nurses Association.

[2] Ibid.

[3] Albert Jonsen, Mark Siegler and William Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*

[4] Verena Tschudin, *Ethics in Nursing: The Caring Relationship* (3rd ed.) (Edinburgh: Butterworth Heinemann, 2003).

[5] Verena Tschudin, Personal communication with author, December 4, 2014.

[6] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (7th ed.) (NY: Oxford University Press, 2013).

[7] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research of the U.S. Department of Health and Human Services, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, D.C.: DHHS/USGPO, 1979), http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html

[8] Jonsen, Siegler, and Winslade, *Clinical Ethics*, 3.

[9] Ibid., 8–9.

[10] Beauchamp and Childress, *Principles of Biomedical Ethics*, 13.

[11] Chris Gastmans, "A Fundamental Approach to Nursing," *Nursing Ethics* 9, no. 5 (2002): 494–507.

[12] Chris Gastmans, "The Care Perspective in Healthcare Ethics," in *The Teaching of Nursing Ethics: Content and Methods*, eds. Anne Davis, Louise de Raeve, and Verena Tschudin (London: Elsevier, 2006), 137, 146–48.

[13] Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 126–34.

[14] Gastmans, "The Care Perspective," 141.

[15] D. Callahan, "Principlism and Communitarianism," *Journal of Medical Ethics* 29 (2003): 288.

[16] Ibid.