

# Ethical Orientation, Functional Linguistics, and the Codes of Ethics of the Canadian Nurses Association and the Canadian Medical Association

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Les textes traitant de déontologie donnent à penser que les structures grammaticales et linguistiques ainsi que les théories qui fondent les orientations éthiques véhiculées par les codes de déontologie influencent la manière dont ces derniers sont reçus par ceux qu'ils lient. Certaines structures grammaticales et linguistiques, par exemple, ont tendance à être directives et bloquantes tandis que d'autres seront stimulantes. Les analyses et les comparaisons des orientations éthiques et des structures grammaticales et linguistiques font ressortir des différences considérables entre le code de déontologie de l'Association des infirmières et des infirmiers du Canada (AIIC) et celui de l'Association médicale canadienne (AMC) quant à ces deux aspects. Ainsi, le code de l'AIIC comporte proportionnellement davantage de déclarations fournissant une analyse raisonnée du comportement éthique, alors que celui de l'AMC a tendance à être plus dogmatique. En revanche, l'analyse de la grammaire fonctionnelle semble indiquer que l'un et l'autre transmettent leur discours sur un ton dont la force ne valorise pas la capacité du destinataire à s'engager dans la voie de la prise de décision discrétionnaire. Néanmoins, le code des infirmières et des infirmiers laisse supposer une relation de collaboration avec le client, tandis qu'on sous-entend dans celui des médecins que le patient est le bénéficiaire de l'érudition de ces derniers. Les auteurs débattent des implications de ces résultats.

The literature on codes of ethics suggests that grammatical and linguistic structures as well as the theoretical ethical orientation conveyed in codes of ethics have implications for the manner in which such codes are received by those bound by them. Certain grammatical and linguistic structures, for example, tend to have an authoritarian and disempowering impact while others can be empowering. The authors analyze and compare the codes of ethics of the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) in terms of their ethical orientation and grammatical/linguistic structures. The results suggest that the two codes differ substantially along these two dimensions. The CNA code contains proportionally more statements that provide a rationale

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for ethical behaviour; the statements of the CMA code tend to be more dogmatic. Functional grammar analysis suggests that both codes convey a strong deontological tone that does not enhance the addressee's ability to engage in discretionary decision-making. The nurses' code nonetheless implies a collaborative relationship with the client, whereas the medical code implies that the patient is the recipient of medical wisdom. The implications of these findings are discussed.

Ethics codes, in an applied context such as health care, are intended to establish a set of standards as a framework for the regulation and enhancement of ethical behaviour. The code of ethics of an organization or profession outlines the practices that are acceptable and unacceptable (Kenny, 1996; Railborn & Payne, 1990). Dean (1992) contends that "codes are meant to translate the more formal philosophical theories of ethics into a set of guidelines that can be applied to the day-to-day decision making" (p. 285).

The historical impetus for the development of ethics codes in nursing was concern over experimentation on human beings during World War II, which led to the *Declaration of Universal Human Rights* in 1948 and an increased focus for health professions on ethical concerns (Kerr, 1991). The International Council of Nurses developed a code of ethics in 1953. The Canadian Nurses Association (CNA) adopted this code but then developed its own document in 1980. Balcom (1994) points out that the first code of ethics for nurses was developed out of need. Specifically, although nurses had been taught to promote the well-being of clients, the public, and families, this obligation was being overlooked. Moreover, according to Balcom, nurses were often told by physicians to follow orders without question, with little consideration being given to the nurses' personal values.

As a result of disagreements with the wording of the 1980 code of ethics, the CNA established an ad hoc committee to revise it. The revision was completed in 1985 following a lengthy consultative process (MacPhail, 1991). Moreover, the CNA has recognized the need to review its code every 5 years, not only because of medical and technological advances but also because of increasing awareness about ethical concerns (Balcom, 1994). The latest version was published in 1997 (Canadian Nurses Association [CNA], 1997a).

The CNA code of ethics is intended to provide guidance in decision-making through a set of values, to serve as a means of self-evaluation, to serve as a basis for peer review, to inform prospective nurses of expectations in the field, and to inform other health-care professionals as well as the general public of the ethical expectations of the nursing profession (CNA, 1997b). The CNA is also explicit regarding what the code is *not* intended to be. Specifically, it is not intended as a

tool for prioritizing nursing values nor as a guide for decision-making in every circumstance that the practising nurse may face.

The Canadian Medical Association (CMA) adopted its first code of ethics in 1868 (Williams, 1994). The code was revised in 1936–37 and again in 1969–70. The most recent version (Canadian Medical Association [CMA], 1996) was prepared following an extensive review, during the course of which the Committee on Ethics attempted to determine the code that would be most appropriate for the medical profession. The Committee did not wish to reduce the code to a set of legal requirements. It took the position that the code should include both a statement of values and principles and a set of guidelines for physician behaviour (Joseph, 1995; Sawyer & Williams, 1996). Following consultation with a variety of CMA committees, councils, and provincial and territorial divisions, the revised code was adopted by the CMA General Council in 1996. Sawyer and Williams identify four goals of the code: (1) improved quality of the physician-patient relationship, (2) improved physician behaviour and guidance in decision-making, (3) improvements in health, and (4) improvements in professional and interprofessional collegiality.

While the extent to which Canadian nurses and physicians use their respective codes in practice is unknown, the empirical evidence from other professions is mixed. For example, Brief, Dukerich, Brown, and Brett (1996) conclude that codes of corporate conduct do not reduce the likelihood of fraudulent financial reporting. McCabe, Trevino, and Butterfield (1996), in contrast, found that the existence of a corporate code of ethics was associated with significantly lower levels of self-reported unethical behaviour in the workplace. Nurses and physicians have at least some familiarity with their respective codes of ethics. While it is unlikely that they consult their code each and every time they are faced with an ethical dilemma, their familiarity with the document is likely to influence the manner in which they approach ethical decision-making.

Given all the functions of codes of ethics, it is of the utmost importance that they be effective means of moderating behaviour rather than merely means of expressing organizational platitudes (Cassell, Jonson, & Smith, 1997). The question becomes, then: What are the most effective components of ethical codes, in terms of both content and design, in achieving optimal ethical behaviour?

Some linguistic and grammatical structures convey content in an authoritarian fashion while others are empowering (Farrell & Farrell, 1998). Similarly, one code of ethics might provide dicta while another

might include an empowering rationale for ethical behaviour. The purpose of our research was to systematically analyze two of Canada's dominant health-care codes of ethics, those of the CNA and the CMA, in terms of their ethical content and grammatical/linguistic structure, in order to examine the implicit meanings conveyed in the two documents.

### **Ethical Theory**

Teleology and deontology are the two mainstream theoretical perspectives that explain and prescribe ethical conduct. The former refers to an ethical perspective in which the ends or consequences of one's actions are paramount. The latter focuses on the means of action (e.g., principles, laws, policies, procedures, and codes) rather than on the outcome.

Teleology encompasses a variety of ends-oriented approaches to ethical conduct. At one extreme, the *individual's* pleasures are paramount and action is geared towards their fulfilment (e.g., Epicureanism). The utilitarians, who view the maximization of happiness for *all sentient beings* as the desired end, occupy the other end of the teleological continuum (Mill, 1833/1985). Utilitarianism can be divided into act and rule orientations. In act-utilitarianism, action that results in the greatest good for the greatest number of people is preferred (MacIntyre, 1966). Many authors (e.g., Williams, 1998) comment that in its pursuit of what is best for the majority, act-utilitarianism may overlook the individual or the minority (Raphael, 1981). To address this perceived shortcoming, a hybrid model was developed that incorporates *a respect for process* in the pursuit of the greatest good for the greatest number. Rule-utilitarianism favours action that results in the desired end through adherence to established rules of conduct; while the end is still paramount, the decision-maker must adhere to certain standards of behaviour.

Deontology focuses not on the ends or consequences of an action but on the means employed in acting. Specifically, deontology is geared towards one's a priori duty to abide by religious, social contract, or rational precepts (Brody, 1983). The dominant form of deontology is based upon the work of Kant (1785/2001), who proposed the categorical imperative as the one universal rule of moral conduct, which can be stated succinctly as: "Act only on that maxim whereby thou canst at the same time will that it should become a universal law" (p. 178). From this perspective, therefore, the consequences of one's action are secondary to one's primary ethical duty. Moreover, there can be no exceptions to one's duty (e.g., "Never tell a lie").

Though much of the traditional debate in ethical theory has focused on teleology and deontology, a third perspective is relevant in the health-care context. This third perspective is called the ethics of “care” (Gilligan, 1982; Noddings, 1984). According to this perspective, the evaluation of ethical conduct is not based on the decision-maker’s ability to determine outcome nor on the duty to follow universal and objective principles. Instead, ethical conduct is a function of the decision-maker’s relationships with others and a commitment to the avoidance of harm — factors that are, one could argue, among the implicit axioms of the health-care professions. The ethics of care attempts to move away from the objectification and abstraction of ethical conduct that characterize the teleological and deontological approaches and towards a subjective and concrete concern with intimate human relations. This care orientation is frequently contrasted with the “justice” orientation of traditional ethical theory and practice (Gilligan). These three disparate approaches (teleology, deontology, and care) form the basic guidelines for our day-to-day ethical conduct. They also constitute the theoretical basis of our organizational and professional health-care codes of ethics. Thus, they are the central foci of our analysis.

### **Codes of Ethics, Ethical Orientation, and Grammatical Structures**

Grammatical analysis of the content of ethical codes can be informative (Farrell & Farrell, 1998). This means of uncovering overt and covert meanings and intentions has had a respectable history since the pioneering structuralist work of Saussure (1916/68) and Meillet (1938) at the beginning of the 20th century. Stylistics and sociolinguistics have both contributed to this kind of analysis. More relevant for our purposes is the grammatical analysis movement based on functional linguistics, an approach that originated with the so-called London School of Linguistics (e.g., Halliday, 1994; Malinowski, 1935). The field of functional linguistics is concerned with the psychosocial function of language and applies the resources of grammatical analysis to the study of discourse in the context of its occurrence and application. This approach represents an internationally respected methodology of textual analysis. For our study, we selected two broad linguistic categories on the basis of content, syntax, and lexico-semantics, because these, far more than phonology (sounds) or morphology (word forms), are expressive of underlying intentions and assumptions.

The literature on the social functions of language supports the assumptions that the surface form of language is expressive of underlying motives and that it generates subtle impacts on the listener or



reader (see Holtgraves, 2002). A command, for example, is more unequivocally expressed in the imperative but, in an appropriate context, can also be explicitly intended through the use of an indicative statement that affects the listener in a different way. For example, the statement "Nurses do X" issues a command in a way that leaves the addressee little room for discretionary decision-making.

While the *intent* of codes of ethics is implicitly accepted and theoretically well documented in the applied ethics literature, their *content* is less well understood and explored. Although the literature on discourse analysis contains many examples of functional analysis of text (e.g., Halliday, 1994; Oktar, 2001), to the best of our knowledge there is only one study (Farrell & Farrell, 1998) that has examined codes of ethics from this perspective. Previous examples of functional grammar analysis include examinations of newspaper texts (e.g., Oktar) and academic mission statements (e.g., Connell & Galasinski, 1998).

Two recent studies examined codes from the perspective of linguistic and ethical content (Farrell & Farrell, 1998; Malloy & Fennell, 1998). Farrell and Farrell investigated the impact of various grammatical structures (i.e., relational clauses, passive voice, grammatical metaphors, and use of modalities such as "can" and "must") on the manner in which ethical behaviour is communicated. They conclude that the language of the Australian codes that they studied constructs an authoritarian writer/reader relationship through overuse of grammatical structures such as relational clauses and passive voice. Farrell and Farrell also demonstrate that such grammatical structures communicate a sense of powerlessness, since they establish a strong authoritarian tone that does not permit the addressee to engage in discretionary decision-making.

Codes of ethics can also be assessed on the basis of ethical theory. Malloy and Fennell (1998) approached the content of codes from this perspective. In their study of codes of ethics related to tourism, they examined the extent to which ethical statements were teleological or deontological. They found that the codes tended to be deontological in nature and did not provide a teleological rationale for code adherence. Thus, the findings of both Farrell and Farrell (1998) and Malloy and Fennell suggest that some codes of ethics are written in a manner that is unlikely to empower those who are faced with difficult ethical dilemmas.

The purpose of the present study was to analyze the ethical and linguistic content of the codes of ethics of the CMA and the CNA. We sought to determine whether differences exist between the grammati-

cal and theoretical orientations of the two documents and to analyze the implicit messages being communicated by them.

## Method

### *Analysis of Ethical Orientation*

The first phase of the research involved a content analysis of the ethical orientation of the CMA (CMA, 1996) and CNA (CNA, 1997a) codes of ethics. Every ethical statement ( $n = 129$ ) in each code was identified as based upon a teleological, deontological, or caring ethical orientation. For our purposes, a *statement* consists of one or more clauses that form a coherent and complete conceptual unit. A statement may coincide with a sentence insofar as it is distinct from surrounding sentences in terms of semantic completeness; or a sentence may be composed of several statements linked by conjunctions such as *and* or *but*. The preambles to the codes were not included in our analysis because they were not considered constitutive of the codes as such.

The following working definitions were used for the purposes of our analysis:

- A statement is *teleological* if it points to some intended outcome of behaviour. This type of statement appeals to consequence (i.e., one should do X because it will result in Y). Consider, for example, the sixth standard listed under the CNA code's principle of *Accountability*: "Nurses, whether engaged in clinical practice, administration, research or education, provide timely and accurate feedback to other nurses about their practice, so as to support safe and competent care and contribute to ongoing learning." In this standard, the explicit teleological consequences for "timely and accurate feedback" are "to support safe competent care and contribute to ongoing learning."
- A statement is *deontological* if it appeals to the duty or obligation of the agent to act in a particular manner without providing a rationale for doing so. Such a statement appeals not to consequence but to duty as a function of professional membership (i.e., one should do X because he or she is a member of our profession). Consider, for example, the second standard of the CMA code: "Treat all patients with respect; do not exploit them for personal advantage." In this standard, no consequence for adherence is provided; it is an assumed duty to respect and not exploit. For this standard to be teleological, the outcome of respect and non-exploitive behaviour would have to be provided. A code could state, for example: "In

*order to enhance the trusting relationship between the patient and the physician, treat all patients with respect; do not exploit them for personal advantage."*

- A statement reflects a *caring ethical orientation* if it implies an interpersonal relationship that is not based on formal policy (i.e., one should do X because it appeals to one's sense of emotional commitment to another person). Consider, for example, the 18th standard of the CMA code: "Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment."

After classifying each statement in the two codes, we tested the reliability of the analysis. Specifically, we assessed interrater agreement (found to be 88%) by having a second judge independently classify a randomly selected subsample of approximately one quarter of the statements.

### *Linguistic/Grammatical Analysis*

Each of the 129 statements (taken together) of the CMA and CNA codes was subjected, by a linguistics expert (Patrick Douaud), to an analysis bearing on seven sub-categories of syntax and lexicosemantics (passive construction, relational process, mode, nominalization, modality, lexical choice, and lexical avoidance). These categories were selected because they are common in codes of ethics. Moreover, several (e.g., passive construction, nominalization) imply a reduction in the addressee's power to make independent decisions and have been used in previous linguistic/grammatical analyses of codes of ethics (Farrell & Farrell, 1998). They differ in this way from other grammatical forms (e.g., tense) that do not vary either within or between codes.

In other words, not all linguistic/grammatical categories are equally exemplified in specialized discourse: passive constructions are used frequently in the directives of authoritarian governments; the relational process is common in publicity slogans; mode varies widely according to intent; nominalization is paramount in academic writing; modality — similarly to mode, but at the level of phrase or clause — expresses emotional nuances; and, finally, lexical choice and lexical avoidance indicate specific trains of thought and political correctness (Halliday, 1994; Kroskrity, 2000). For the purpose of this study we chose grammatical categories on the basis of: (a) distribution, as they are commonly found in non-literary written discourse (Fawcett & Young, 1988); and (b) common sense, as a cursory linguistic examination at the ethical



codes under study quickly revealed that the selected categories were all present to varying degrees. The functions of these categories are as follows:

- *Passive constructions* depersonalize the action and remove the focus from the participants (e.g., “appropriate care is provided until alternative care arrangements are in place” [CNA principle of *Choice*; Standard 5]). The passive voice allows for flexibility of clause structure but may omit the participant from the clause, thus having a negative impact on interpersonal function (Farrell & Farrell, 1998).
- The *relational process* uses verbs that imply inevitability (e.g., is, are) and therefore leaves no room for options (e.g., “Recognize that community, society and the environment are important factors in the health of individual patients” [CMA Standard 29]; “self-regulation of the profession is a privilege” [CMA Standard 35]). The central meaning of the relational process is that “something is” (Halliday, 1994).
- As a syntactic device, *mode* allows the verb to express facts, commands, and wishes. Our focus was the *indicative* (e.g., “Nurses foster well-being” [CNA principle of *Health and Well Being*; Standard 6]) and the *imperative* (e.g., “Use health care resources prudently” [CMA Standard 32]). The former implies fact, the latter authority (Thompson, 1996). We chose to focus on these two modes because other modes (e.g., the *interrogative*, which is used to question) are not often used in ethics codes. The classification of the *mode* involves a different level of analysis from the identification of *relational processes*. For example, a statement can be defined both as indicative and as involving a relational process.
- *Nominalization* refers to the process by which a noun or noun phrase is formed from another syntactic category without clearly identifying a subject or agent (e.g., “the development, implementation, and ongoing review of policies” [CNA principle of *Fairness*; Standard 5]). This process depersonalizes the participants and blurs the line between their various roles (e.g., Thompson, 1996).
- *Modality* (Halliday, 1994) refers to the verbal expression of nuances that allow for judgement and opinion (such as the words *can, will, shall, should, could, may*) (e.g., “there should be no fee for such treatment” [CMA Standard 11]).
- *Lexical choice* (e.g., MacKay & Konishi, 1994) can be used to challenge widely held assumptions (e.g., *rebellion* vs. *resistance* in Canadian aboriginal history, or, in the present context, *client* vs.

*patient*). Our inclusion of lexical choice was motivated by the striking difference between the two codes in their use of the terms *client* and *patient*.

- *Lexical avoidance* refers to the universal practice of replacing words that are deemed embarrassing or taboo with euphemistic words or phrases. Common examples in modern English are the use of *passing on* instead of *dying* and *terminate* instead of *kill*. This category was chosen for the present analysis because of the sensitive nature of words related to death and dying in health-care contexts.

## Results and Discussion

### *Ethical Orientation*

Our analysis of the ethical orientation of the CMA and CNA codes suggests substantial differences between the two (see Table 1). The CMA code exemplifies a dominant theme of deontology insofar as 49 of the statements (instances-to-statements ratio = .94) relate to the physician's obligation to abide by his or her duty to the patient and/or profession. Of the remaining statements, two (instances-to-statements ratio = .04) relate to a teleological rationale and one (instances-to-statements ratio = .02) focuses on caring. The CNA code demonstrates a much broader scope in terms of its ethical orientation. Of the 77 statements analyzed, 53 (instances-to-statements ratio = .69) are deontological, 10 (instances-to-statements ratio = .13) are teleological, and 14 (instances-to-statements ratio = .18) reflect the ethics of care.

The finding that deontological theory provides the basis for the majority of statements in both the CMA and CNA codes is not surprising, because their implicit and explicit deontological rationale for ethical conduct is rule-adherence (i.e., duty). This finding suggests that both physicians and nurses belong to professions in which individuals are expected to abide by a code of ethics as a function of their professional duty. While this sense of duty is strongly communicated in both codes, there do exist some interesting differences. The CMA provides the reader little latitude in terms of the rationale for ethical conduct, as 94% of statements are duty-bound. The reader is provided with some further rationale in only 4% of the remaining ethical statements, such as "Engage in lifelong learning to maintain and improve your professional knowledge, skills, and attitudes" (Standard 5). Thus, the focus is on the means, as opposed to the ends, of one's conduct (viz., Do your duty). The outcome of or rationale for one's action is either presumed to be implicitly known by the physician or of secondary importance to duty.

Though the majority of statements in the CNA code are deontological, the teleological and caring perspectives are strongly represented. This wider scope suggests that Canadian nurses are more concerned than physicians about understanding the effect that their behaviour will have on clients' health and on their relationship with their clients. The CNA appears to be interested in employing the code of ethics as an educational tool as opposed to merely as a professional dictum.

### *Grammatical Structure*

Grammatical categories and sub-categories tend to overlap to some extent. However, it is possible to do a rather precise analysis of the differences in tone and intent between nurses' and physicians' codes of ethics, thanks to the narrow range of the categories employed and the clear, step-by-step format characteristic of these codes.

The results of our linguistic analysis are summarized in Table 1. Passive constructions are used in 20% of the CNA code's 77 statements

<b>Table 1</b> <i>Instances-to-Statements Ratios Based on Ethical Orientation and Functional Grammar Analyses of the CNA and CMA Codes of Ethics</i>		
	<b>CNA</b> (77 Statements)	<b>CMA</b> (52 Statements)
<i>Ethical Orientation Analysis</i>		
Deontological statements	.69	.94
Teleological statements	.13	.04
Ethics of care	.18	.02
<i>Functional Grammar Analysis</i>		
Passive constructions	.20	.17
Relational process	.31	.17
Nominalization	.82	.65
Indicative mode	used throughout	.04 (one instance)
Imperative mode	not used	used throughout
Use of modalities:		
can	.01	.02
would	.03	.02
must	.01	0
might	.01	0
should	.01	.02
will	.14	.04

and 17% of the CMA code's 52 statements. Thus, both codes show the depersonalizing tendency common in official documents that strive for detachment and objectivity. However, use of relational process (verbs implying inevitability) is much more pronounced in the CNA code (24 instances; instances-to-statements ratio = .31) than in the CMA code (9 instances; instances-to-statements ratio = .17). This points to a more categorical tone for nurses and a more guarded tone for physicians — members of a profession that is considered to represent the highest authority with respect to health-care decisions.

The divergent use of mode is striking, with the indicative being employed throughout the CNA code (e.g., "Nurses seek," "nurses provide") and the imperative throughout the CMA code (e.g., "Consider," "Recognize"). Thus, the CNA code presents its statements in a way that implies fact, whereas the CMA code is written in an imperative, authoritarian fashion. Despite this difference, the manner in which the indicative is used in the nurses' code is rather disempowering as it leaves little room for options. More specifically, the statements in the CNA code often take the form "Nurses do X," which does not allow much room for choice or discretion.

The frequent use of nominalization (63 instances, or an instances-to-statements ratio of .82, for nurses, compared with 34 instances, or an instances-to-statements ratio of .65, for physicians), with its accompanying depersonalizing effect, reinforces the impact of passive constructions. Examples of nominalization include "Where disclosure is warranted" (CNA principle of *Confidentiality*, Standard 3) and "When the maintenance of confidentiality would result" (CMA Standard 22).

Passing now from the analysis of syntax to that of lexico-semantics, we discover that the use of modalities (i.e., verbal expressions of judgment and opinion) shows a similar pattern. Whereas the two codes contain comparable numbers of expressions of mild obligation (namely *would* and *should*), the CNA code contains many more expressions of higher-level obligation: 11 instances of *will* (instances-to-statements ratio = .14) and 1 instance of *must* (instances-to-statements ratio of .01); the corresponding instances in the CMA code are 2 (.04) and 0.

As noted, the most striking feature in terms of lexical choice is the systematic use of *client* in the CNA code and *patient* in the CMA code. The former suggests a two-way interaction, with clients actively involved in their care and nurses providing guidance; the latter suggests a one-way interaction, with the patient playing a passive role and the physician taking over care of the individual's health. While it might be suggested that the specific connotations of the two terms have been

attenuated to some extent in practice, it is nonetheless noteworthy that the codes themselves contrast so sharply in this respect.

Lexical avoidance in this context involves the word *death*, a source of considerable unease in Western culture, especially in the medical field where death is sometimes equated with failure. Predictably, the CMA code exhibits a remarkable degree of lexical avoidance, not mentioning *death* even once; the closest it comes to the topic is in Standard 3: "when cure is no longer possible..." In the CNA code, in contrast, *death* is mentioned twice: "process of dying" and "peaceful death" (both under the principle of *Health and Well Being*). Nurses typically spend long hours in close contact with the sick, are trained to assist the sick in all circumstances, and come to accept the inevitability of death as part of their routine. Physicians may be somewhat more remote in their interactions with patients. Although the two codes are equally binding, we can perhaps read into the CMA code a tone of authority towards patients, while the CNA code could be seen as encouraging nurses to work collaboratively with their clients. In terms of the ethics of justice and care, the CMA code is more congruent with the former and the CNA code with the latter.

### **Conclusions and Future Directions**

Although the relatively higher proportion of teleological statements in the CNA code provides the addressee with a rationale for ethical behaviour and thus enhances empowerment, the functional grammar analysis suggests that both codes are written such that the addressee is offered few opportunities for discretionary decision-making. Moreover, both codes reveal many instances of impersonal constructions (e.g., passive voice). While use of the imperative and the indicative (which, at least in these codes, are authoritarian constructions expressing commands, wishes, and facts) may be inevitable in codes of conduct, the authoritarian impact of such constructions can be moderated in a variety of ways — for example, through the use of conditional statements (if X, then Y), phrasing that implies an effort to accomplish an end (e.g., "Nurses strive to do X" as opposed to "Nurses do X"), and words that imply a choice or exception (e.g., avoid, or, normally, but, however). Choice allows decision-makers to consider special circumstances. There are few such instances in these codes. For example, the conditional mode is used only three times in the physicians' code and twice in the nurses'. Moreover, we found few additional attempts to moderate the authoritarian impact of statements in the CMA code (e.g., Standard 13, "Make every reasonable effort to...") and in the CNA code



(e.g., principle of *Choice*, Standard 1: "Nurses seek to involve clients"). In the case of the nurses' code, three of five such instances are associated with the principle of *Choice*.

Nonetheless, we found numerous concrete examples of such moderating statements in another professional code of ethics, namely that of the Canadian Psychological Association (2000). We present a few of these here with the relevant constructions italicized: "Personal behaviour becomes a concern of the discipline only *if it...undermines public trust in the discipline as a whole or if it raises questions about the psychologist's ability to carry out appropriately his/her responsibilities as a psychologist*" (p. 6); "This responsibility is *almost* always greater than their responsibility to those indirectly involved" (p. 8); "*Strive* to use language that conveys respect for the dignity of persons *as much as possible* in all written and oral communication" (p. 9).

Given that ethical dilemmas can rarely be resolved in a categorically right or wrong way, it is important that decision-makers be empowered to consider special circumstances when faced with such dilemmas. Although the preamble to the CNA code indicates that nurses should consider the specific circumstances of each ethical dilemma (and that nurses may disagree about the relative weight of the various ethical principles), the grammatical structures employed throughout the document do not always convey this message effectively. The results of our functional grammar analysis lead to the conclusion that the CNA code is written in a fashion that implies teamwork and a collaborative relation with clients/patients, and that the CMA code, in contrast, views the patient as a passive recipient of medical wisdom.

Our analytic approach has several practical implications. By making explicit elements that are hidden in code structure, one can foster a more thorough understanding of a code's impact and coherence. The CMA code, for instance, could be enriched with the addition of teleological statements that complement its deontological emphasis, through the provision of a rationale for ethical behaviour. It could also be enriched through the use of more care-oriented expressions of mutual help such as those found in the CNA code. Similarly, our analysis points to the need for greater attention to grammatical structures and their implications, as well as to lexical choice; with respect to the latter, the CNA's use of the term *client* instead of *patient* is particularly felicitous at a time when the notion of interactional passivity is increasingly unwelcome. The debate on use of the terms *client* and *patient* in health care is analogous, in some respects, to the debate on use of the

terms *participant* and *subject* in human research (Danzinger, 1990). While *patient* and *subject* have a more specific meaning, they also connote passivity; *client* and *participant* are more wide-ranging, less precise terms but convey a sense of active involvement or engagement. Although these connotations can to some extent be attenuated in professional practice, they cannot be fully eliminated, as they are ultimately a function of broader linguistic practices. The information presented here can serve as a reminder that, under careful analysis, the elaborated text reflects on the author of the code and the intended audience as well as its assumptions.

It should be noted that the two codes of ethics are designed to offer guidance, as stated in both preambles. Moreover, according to the preamble to the CNA code, the document is intended to be educational. Modifications to the writing style (e.g., to allow room for carefully thought out, flexible decision-making) and content (e.g., the provision of an educational, teleological rationale for ethical behaviour) would serve to enhance these noble goals.

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#### Authors' Note

This research was supported in part by a Social Sciences and Humanities Research Council of Canada operating grant to David C. Malloy and Thomas Hadjistavropoulos.

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