ETHICS IN NURSING: THEORY TO PRACTICE

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Implicit in the **Code of Ethics for Nursing** (Canadian Nurses Association, 1983) and in the **International Council of Nurses Code for Nurses** emphasis on "respect for life, dignity and the rights of man" (Canadian Nurses Association, 1980), is the idea that there is a bond between nursing and society. This bond serves to encourage a relationship of trust and confidence between society and the nurse; moreover, within the profession, it serves as a statement of role morality (Curtin & Flaherty, 1982). While the ethical codes supply the profession with rules, these rules should be understood in the context of underlying ethical theories and principles. This paper deals with the relationship between two ethical theories and nursing practice. The discussion will be focused around a specific hypothetical example.

Normative Ethical Theories

Two ethical theories that are pertinent to nursing require elaboration. They are the teleological theory originated by Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873), and the deontological theory originally propounded by Immanuel Kant (1724-1804). Reinforcing each theory are principles of ethics, and it is to these principles that nurses must appeal when considering and justifying nursing action.

Teleological theory

Teleological ethical theory, sometimes termed utilitarian theory, is based on the principle of utility that was originally defined by Mill (1972) as the seeking of pleasure and freedom from pain. The original concept of "pleasure" referred to the intrinsic superiority of pleasure that springs from, and contributes to, the dignity of humans of "higher consciousness" (Mill, 1972, p.9). Over time the word pleasure came to have a more colloquial meaning, and Mill's principle drew much criticism. Recently, Beauchamp and Childress (1979) have interpreted "utility" to mean that one ought, in all circumstances, to produce the greatest possible balance for society of value over disvalue, so that cost and suffering is minimized; or benefit is maximized.

Teleological theory can be described as being based on **acts** whereby the consequence of each act is assessed individually, or based on **rules** whereby the end sought is based on maintaining

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social integrity. This latter basis was important to Mill, who always looked to the interest of the whole, and it has become, in general, the more accepted teleological approach.

Problems arise with this theory when efforts are made to characterize the pleasure, value, or benefit of the outcome, whether act or rule teleology is used. This problem becomes critical when long term consequences are being calculated.

Deontological theory

Conversely, deontological theory, sometimes termed formalist theory, is concerned with universal self-consistent values, obligations, and commitments. To Kant (1956), who first stated this theory, an action has moral value when it is rationally willed; is done for the sake of duty; considers persons as ends; and has, at its base, a principle that is acceptable as a fundamental moral law by all rational beings. Here the concept of duty is primary, and is quite independent of the concept of pleasure: the motives for "acceptable" actions are paramount, although outcomes can be taken into consideration.

Rational explanations in deontological theory, unlike teleological theory with its one principle of utility, are based on several fundamental ethical principles. The succeeding ethical principles can be used to defend a position that is critical to the well-being of an individual in the health care system: these are, justice, beneficence, nonmaleficence, autonomy, and veracity.

The principle of justice is based on the idea of human reciprocity and fairness (Rawls, 1978). Two aspects of justice can be considered in relation to the health care system: justice is said to be comparative when the claims made by different individuals compete for ligitimacy, and noncomparative when independent standards are set (Beauchamp & Childress, 1979). The principle of beneficence refers to the duty to take positive steps to enhance the welfare of others (Fagothey, 1963). Beauchamp and Childress (1979) distinguish between aspects of this principle: the conferring of benefits and prevention of harm versus the apportioning of good to provide for the greatest possible overall good. On the other hand, the principle of nonmaleficence is concerned with the moral obligation to consider risks and to weigh them against potential benefits (Beauchamp & Childress, 1979). This is accompanied by the duty to prevent harm. By the principle of autonomy, Kant meant will plus self-legislation in accordance with what would be valid for everyone; in other words, it encompasses the right to act on one's own values, according to one's own beliefs, with a need for the least possible interference from anyone, but, with the stipulation that one would agree that it is acceptable, in general, for others to act in the same or a similar manner (Aune, 1979). Today it is interpreted to mean personal liberty of action when accompanied by the ability to plan and select from socially

acceptable alternate behaviours (Beauchamp & Childress, 1979). The final principle is that of veractiy. It relates to the duty to tell the truth that is part of the respect we owe other persons (Beauchamp & Childress, 1979). Ramsey (1979) goes so far as placing this principle in the realm of fidelity, as it pertains to the bond between "consenting man and consenting man" (p.5). This relationship leads to partnership, and partnership can only be possible when it is based on veracity (Ramsey, 1979). According to Veatch (1976) individual patients have a right and obligation to have the truth. He notes that, "Rarely is withholding information potentially useful or meaningful to the patient to be condoned" (p.248). With the deontological theory, determining which principles to use and which deserve priority can be a challenge requiring considerable analytic thought.

Ethical Principles in Nursing Practice

For both theories, there are limits to what is considered ethically relevant. Ethical relevance is conceptually connected with the situations that require justification for actions. Principles imply rules and it is, in general, these rules that constitute the ICN and CNA codes of ethics and help the nurse to establish his or her duties and obligations. Hence, when adhering to the directive pertaining to respect for life, dignity, and the rights of man, it is necessary for the nurse to know how to apply this rule. Since this rule functions to encourage relations of trust and confidence between society and the professional, the nurse ought to know on what principles decisions are based, and, concomitantly, be aware of the ethical theory he or she is drawing from. Then pertinent facts can be articulated, decisions defended, and actions justified. Often a well substantiated point of view can be arrived at through interdisciplinary dialogue whereby uncoerced agreement on a mode of action is collaboratively decided upon. In these instances, the nurse, in defining nursing's role, has not only to establish his or her duties and obligations and be accountable for all actions, but he or she must also answer to diverse and often conflicting demands from the institution, the administration, the physician(s), the individual involved, and, perhaps, the family.

In seeking answers to ethical questions and then in supporting a nursing position, the nurse uses the nursing process in a broader and more comprehensive manner. Special awareness of the ethical dimension must be maintained as data are collected, analyzed, and interpreted in accordance with the selected conceptual model for nursing. The following outline (see Model 1 in the appendix) suggests a way in which the nursing process can include the ethical dimension of nursing practice. The nursing model would serve to direct the definition of the client, the role of the nurse, the intervention focus and modes, and the anticipated consequences. A hypothetical clinical example provides background for a discussion on theoretical application. This discussion is followed by a more abstract review of nursing responsibility.

Clinical Example

Mrs. K is a 35 year old woman with a history of occasional depressive episodes. She has been at home caring for her two children, aged one and three years. Prior to her first child, she had successfully managed a clothing store. Her husband is a busy executive, working for a computer company.

At present Mrs. K is a voluntary patient in a psychiatric facility and is experiencing her second depressive episode in three years. She has been on medications but now her physician tells her he is going to order a series of ECT treatments. Prior to withdrawing even more, Mrs. K refuses the treatments and asks if something else could be done for her. Meanwhile, her husband, frustrated by the conflicting demands of caring for a depressed wife, two young children, and a demanding job, insists she have the ECT.

Application of Theory

Within the context of this example, a nurse who is cognizant of the rules inherent in the codes of ethics, and who desires to structure nursing practice so that promoting patient rights and supporting patient dignity remain a priority, must formulate a solid rationale for his or her own decisions. Thus the nurse is motivated to add to the concepts, ideals and behaviours that constitute a value system and provide meaning to personal and professional life. This can be done when ethical theories and their respective principles are used effectively. What must the nurse know to develop such an argument? To some extent this is well defined: the nursing process must be used in a systematic and scientific manner. A nursing model is vital because it provides direction for the nursing process; theoretical and technical nursing skills are imperative, and of course, knowledge pertaining to legal requirements and professional standards remains essential; furthermore, all care must be grounded within an ethical ideal such as that espoused by the nursing codes. Then, once ethical theories are learned, promotion of the nursing perspective can be grounded in theory and articulated with support from appropriately selected principles. In short, the situation is examined from an explicitly ethical viewpoint.

With Mrs. K, as relevant data are gathered, it becomes evident that Mrs. K's rights are at risk. The preference she holds - the request for more information and the denial of ECT - is not respected. As data are analyzed it becomes apparent that an ethical conflict exists. Without adequate information and support directed toward increasing Mrs. K's self-determination, it is impossible to maintain a respectful relationship. Her dignity is compromised. The nurse, directed first by one of several nursing models, which, in general, state that the goal of action is to promote optimal functioning, optimal adaption, or independence for the patient, and secondly, by the code for nurses, identifies the

ethical principle perceived to be most at risk. Then, an examination of the interrelationship between the principle(s) and the conflict is undertaken. The nurse must now turn to an analytic comparison of theory and principle as he or she seeks to shift the focus of power and responsibility back to Mrs. K.

Deontological analysis

The concept of respect as addressed by the Code, leads the nurse to consider ethical principles which lead to affirmation of Mrs. K's personhood. At this point the nurse will consider the principle of nonmaleficence and perhaps even beneficence. The questions are: Will nursing interventions be geared toward promoting a positive good (i.e., supporting Mrs. K's request for more information, and then ascertaining what Mrs. K really is willing to have done); or, will nursinsg interventions, at the very least, be directed toward causing no harm (i.e., acquiescing with the medical order, and permitting or promoting it if it is believed no harm is likely to befall Mrs. K)?

On the other hand, the nurse may choose to consider the principle of autonomy: Mrs. K is considered a many faceted being with varying needs and goals, the disease process being but a symptom of lack of need fulfilment. Since nursing models direct the nurse toward considering wellness for the whole person, once again ways of promoting Mrs. K's ability to voice her own perspective - to rule her own being - must be found. Mrs. K's request, its lack of immediate acknowledgement and her subsequent deepening of depression, may suggest that she senses an even greater loss of self control.

Another principle that deserves consideration is the principle of justice. There is no mention of scarce resources, so justice will be considered on the noncomparative basis. What is fair for individuals in this or similar situations? A most difficult question. How do nursing duties and the subsequent need for accountable action relate to nursing motives when this question is answered? While the medical decision may have been based on the physician's concern for the family and its need of a functional mother, and on a belief in the effectiveness of ECT, it nevertheless remains that Mrs. K does not wish ECT and did explicitly request that other treatments be considered. Furthermore, since she did ask if there was not another approach, she does have the legal right to more information. This leads to consideration of the principle of veracity - especially as it pertains to informed concent. Given that truth telling and the providing of information demonstrate respect for the dignity and legal rights of Mrs. K, given that Mrs. K is a voluntary patient and thereby maintains her freedom of choice, and given the fact that she is adverse to having ECT, what does this mean in terms of accountable nursing action? The nurse has the necessary knowledge and legal sanction to disclose a reasonable amount of information. But, is the right to disclose

such information considered to be within the scope of the nursing role?

Application of the deontological theory supports an explicit conceptual basis for justifying a rationale, grounded in the concept of duty as interpreted through various of the aforementioned principles. However, how can a position be stated that fulfils an obligation to Mrs. K, remains professionally accountable (which includes independent, dependent, and interdependent nursing functions), and incorporates full participation as a member of the health care team? Another difficult question. To answer all of these questions it is necessary to determine clearly the relationship between factual data pertinent to the conflict, such as the involvement and perspective of all pertinent others and institutional policies, and the principle selected as being the most important for nursing to uphold. A critical awareness of this relationship leads to formulation of a well articulated statement that promotes the kind of action chosen and gives full professional scope to the nursing role.

Example: Assume that the nurse chooses to base the nursing perspective on the principle of justice. As the nurse completes the assessment phase (see Model 1), the belief that before Mrs. K can become an active participant in her own care and, concomitantly, garner self-respect and that of others, she must know what realistic options are available, and then must be encouraged to explore the potential outcome of each alternative. This rationale leads to a problem statement: Increased withdrawal behaviour consequent to refusing ECT treatments, and a request for more information on treatment alternatives. The planning phase is then initiated, and a request is made for a team conference.

Effective communication is vital at this point. In this instance, the nurse knows that, for nursing, the desired outcome for Mrs. K involves her active participation in the setting of short- and long-term objectives that will assist her in resolving issues that have led to her withdrawn state. Therefore, the nursing perspective is derived from the relationship among justice and fairness and Mrs. K's withdrawn behaviour. In conference, the nurse states the problem, outlines several possible outcomes, and explains the rationale with reference to, for example: the **Patient Bill of Rights**; the legal stipulation that a reasonable amount of information, based on what a reasonable person would consider adequate, is necessary before consent to treatment is considered informed; and the right of the nurse to document patient problems responsibly, as the nursing process and model for nursing dictate.

As team members respond to these points and bring up others, creative alternatives for care can evolve. Once a unified approach is agreed upon, the nurse develops a care plan, which is based on the best possible alternatives, making certain that the plan and the documentation that supports it remain as congruent as possible with the selected principle. (In the event that the treatment option is

not modified, the nurse has voiced a concern, documented a perspective, and thereby stood up for an ethical standard of nursing care.) As the plan of care is implemented, ethical awareness never wavers - the degree to which the selected ethical principle is upheld requires continual reassessment. As the plan is evaluated, the nurse checks for ethical conflict and shifts in conflict, refining the care plan as necessary. What is more, the result of the evaluation can be used to help identify and plan more effective ways of coping with future conflict situations.

Teleological analysis

If, on the other hand, the nurse chooses to substantiate a perspective backed by the teleological theory, with its focus on instrumental value in terms of benefit to society as a whole, the principle of utility is applicable. This principle, as previously addressed, refers to the calculation of greatest value, or benefit. the nurse is required to assess the immediate and long term consequences of the proposed medical decision, versus Mrs. K's specific request. For the nurse to establish a well supported position, alternate interventions, as they relate to the best possible outcome (as far as nursing is concerned), require justification. Moreover, while Mrs. K is to benefit directly the decision should, to remain consistent with rule teleology, be generalizable so that it reflects a general benefit for others in similar situations.

Application of theory here requires that the motive for action be based not on the most expedient action, but on the action felt to be the most beneficial for the consumer in general. A societal sanctioning is required. Hence, the nurse must reflect on limits and ask: How much should Mrs. K, or others in a similar situation, be told? What are the long term consequences of treating others in the same way that Mrs. K is about to be treated? If an exception is made in the case of Mrs. K (i.e., a specific decision regarding this one case, such as in act teleology), then a solid rationale is still necessary and it should be based on limitations previously defined in the institution's policy.

Example: The principle of utility becomes primary and, although the problem statement remains the same, the structure of the argument that supports patient outcomes differs. Instead of the duty oriented premise based on justice and fairness, the nurse now turns to pragmatic arguments that build on what is the most efficient and effective outcome for Mrs. K (i.e., what will maximize benefit and minimize risk). Again, in conference, the nurse cites the problem statement, the potential outcomes, and then substantiates the nursing view by making reference to, for example: those who will most likely suffer if Mrs. K is treated in a way that makes her feel even more dependent and powerless; the fact that Mrs. K has previously been a competent, independent decision-maker in business and needs to recapture these decision-making skills if her young children are to benefit; and the

notion that, if the philosophy and policies of the institution maintain the right of the patient to participate in decision making - or the need to promote self-responsibility in patients - then failure to follow this philosophy can result in a general disregard of policy, which in the end, will have negative effects on consumers and health care professionals alike. In essence, the nurse is pointing out the risks involved if Mrs. K is not encouraged to be autonomous, while indicating that there are risks involved, on an attitudinal level, for the health care team if standards set by the institution are not upheld. Following the conference, a care plan is developed and implemented. Reasoning that supports the focus of the plan is documented on the chart. Again, as in the previous example, a dualistic view of evaluation is taken as decisions regarding the quality of the resolution are made, while, at the same time, content that will promote further learning is sought.

In summary, it should be noted that, although the basis for decision-making may be different (the principle of justice versus the principle of utility), the problem statement and patient outcomes may be the same or similar. The difference lies in the structure of the reasoning. However, it is the quality of the reasoning and the competent way it is presented that will give greater responsibility to the nursing role by broadening the professional nature of nursing practice.

Nursing Responsibility

When a nurse uses the nursing process and nursing model in conjunction with ethical principles, scientifically based humanitarian care is offered. This type of care requires accountable nursing action based on nursing's independent function. Concretely, when our Code directs us to be responsible primarily "to those people who require nursing care," and to "promote an environment in which values, customs, and spiritual beliefs of the individual are respected," we cannot ignore the very deontologic framework evident in the statement, "Inherent in nursing is respect for life, dignity and the rights of man" (Canadian Nurses Association, 1980). We, in the Kantian sense, have a duty - a duty that incorporates accountability to the individual we care for. In this case we are directed to consider universal and self-consistent values that promote dignity and respect for patient rights. Conjointly, consequences viewed via the teleological perspective warrant consideration. Nurses must believe that interventions, while providing benefit for the patient, are good for society in general.

If nurses are to stand firmly as independent practitioners, especially when faced with conflicts attributed to new technology and to the array of invasive therapies available today in health care, we must feel confident of our knowledge in the above areas. We need to concentrate on grounding the Code in daily practice by gaining knowledge of ethical theories and by developing an

We need to concentrate on grounding the Code in daily practice by gaining knowledge of ethical theories and by developing an awareness of the application of their respective principles to the nursing process, and subsequently to nursing care. Once ethical principles are linked to the Code, and are referred to in decisions and justifications for nursing care, we can state an independent nursing judgment with pride and confidence.

However, nurses are not the only members of the health care team; indeed, expertise is shared. When we define the scope and nature of the nursing role, the interdependent or collaborative function becomes important; however, when conferences are held on conflicting issues in patient care, nurses should clearly state their independent viewpoints. This means that the nurse, using analytic abilities and communication skills, can present Nursing's position with as much force as other disciplines present their views. Then, in cooperation, it becomes possible for complex human problems to be resolved in a manner whereby all members of the health care team listen to and assist competent patients as they participate in designing their own care plan.

Thus, the nursing role evolves, and as nurses become more sure of themselves, and of the right of the nursing profession to develop the independent and interdependent dimensions of its role, the profession will grow as will the nurses.

Conclusion

Many nurses are caught in a dilemma. Arsokar and Veatch (1977) and, Curtin and Flaherty (1982) note that nurses often revert solely to their dependent role, making few significant contributions in times of conflict. It follows, then, that there are times when nurses permit, or even promote, a medically devised plan of action when they either feel unconvinced professionally of its benefit or value, or when they realize that the individual they are caring for has not been adequately consulted.

This paper refers to the duties promulgated in codes of ethics for nurses (Canadian Nurses Association, 1980 & 1983), and deepens the grounding for the rules within the codes by using the nursing process to outline how two ethical theories and their respective principles can relate to a concrete case.

Since there is a difference in the character of the theories, one may suit the temperament of certain nurses more than the other, or suit one situation better than another. Nevertheless, each theory, when used with the nursing process as recommended, can lead to principled reasoning that reinforces the independent function of the nurse's role. Moreover, a well substantiated viewpoint provides the basis from which to begin interdependent decision-making.

In conclusion, all nursing codes speak to the moral quality of nursing acts and outline certain standards for ethical behaviour. In fact, the new CNA **Code of Ethics for Nursing** (Canadian Nurses Association, 1983), in stating, "It is the obligation of nurses to communicate the conditions essential to nursing practice to other disciplines and to society," requires that nurses know how to formulate a well thought out nursing position. Hence, knowledge of ethical theories and principles used in conjunction with the Code and linked to an explicit nursing framework, while admittedly a complex undertaking, is a feat most necessary to modern day humanitarian and caring professional nursing practice.

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Model 1

The Nursing Process: An ethical expansion

Assessment

Objective: Collection and analysis of relevant data

1. Gather relevant data

   (a) Elicit pertinent background information re past and present (the nursing model directs you to do this)
   (b) Ascertain the client's perspective
   (c) Identify the meaningful others
   (d) Gain their perspective on the situation
   (e) Acknowledge institutional philosophy and policies pertaining to this issue.

2. Analyze relevant data

   (a) Specify nature of ethical conflict
   (b) Identify ethical theory
   (c) Identify pertinent ethical principle(s)
   (d) Determine the interrelationship between the conflict and the principle(s)
   (e) Identify priority ethical principle(s)
   (f) Develop problem statement(s) based on ethical principle(s).

Planning

Objective: Identification of real and/or potential problems accompanied by a goal statement

1. Utilize resource personnel

   (a) Involve nursing administrators, family, pastoral services and other members of health care team as necessary
   (b) Call team conferences as appropriate
   (c) Identify alternatives for care based on the selected principle(s).

2. Develop care plan

   (a) Plan nursing care based on the best possible alternative
   (b) Document reasoning justifying nursing action(s) as directed by ethical principle(s).

Implementation

Objective: Activation of nursing care plan

1. Validate care plan
   (a) Validate plan with client and appropriate family members as well as with pertinent members of the health care team.

2. Assess care plan

   (a) Identify effect of nursing care
   (b) Clarify degree to which selected ethical principle(s) are upheld
   (c) Assess the continuing complexity of the conflict.

3. Augment the care plan

   (a) Provide additional necessary nursing input
   (b) Support the client and the family
   (c) Update appropriate members of the health care team.

Evaluation

Objective: Critical review of outcomes and pertinent refinement

1. Focus on problem resolution

   (a) Compare outcome(s) to goal(s)
   (b) Ask, does ethical conflict persist? or, has the focus shifted?
   (c) Refine care plan as necessary.

2. Consider ethical dimension

   (a) Clarify degree to which ethical principles were upheld
   (b) Summarize principles which were overruled
   (c) Discern degree to which conflict resolution met the standards espoused by the code of ethics
   (d) Share outcome of comparison with health care team
   (e) Accept feedback
   (f) Plan more effective ways of coping with future conflict situations.

RÉSUMÉ

Soins infirmiers et déontologie: De la théorie à la pratique

Les codes de déontologie ont été mis au point pour offrir des lignes directrices aux infirmiers. Cependant, quand des situations conflictuelles apparaissent en milieu clinique, il arrive souvent que les infirmiers ne savant pas comment utiliser ces directives pour proposer des justifications fondées de leurs interventions infirmières. Le présent article fait état de deux théories morales qui s'appuient sur des codes de déontologie; on démontre également comment ces préceptes et ces principes contribuent à leurs théories respectives et offrent un exemple de la façon dont l'analyse théorique peut avoir des applications pratiques en soins infirmiers.