CODE OF Ethics

FOR REGISTERED NURSES

2008 CENTENNIAL EDITION

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

All rights reserved. No part of this document may be reproduced, stored in a retrieval system, or transcribed, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without written permission of the publisher.

© Canadian Nurses Association
50 Driveway
Ottawa, ON K2P 1E2

Tel.: 613-237-2133 or 1-800-361-8404
Fax: 613-237-3520
www.cna-aiic.ca

June 2008

ISBN 978-1-55119-182-9

CONTENTS

Preamble 1
Purpose of the Code 1
Foundation of the Code 2

Using the Code in Nursing Practice 4
Types of Ethical Experiences and Situations 6

Part I: Nursing Values and Ethical Responsibilities 8
A. Providing Safe, Compassionate, Competent and Ethical Care . . 8
B. Promoting Health and Well-Being 10
C. Promoting and Respecting Informed Decision-Making 11
D. Preserving Dignity 13
E. Maintaining Privacy and Confidentiality 15
F. Promoting Justice 17
G. Being Accountable 18

Part II: Ethical Endeavours 20

Glossary 22

Appendices 29

Appendix A: The History of the Canadian Nurses Association Code of Ethics 30

Appendix B: Context of the Code 31

Appendix C: Ethical Models 36

An Ethical Model for Reflection: Questions to Consider 36

Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications 39

Appendix D: Applying the Code in Selected Circumstances 41

Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care 41

Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience 43

Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic 46

Ethical Considerations in Relationships with Nursing Students 49

Acting Ethically in Situations That Involve Job Action 50

References 52

Ethics Resources 57

PREAMBLE

The Canadian Nurses Association's *Code of Ethics for Registered Nurses*[1] is a statement of the ethical[2] **values**[3] of **nurses** and of nurses' commitments to persons with health-care needs and **persons receiving care**. It is intended for nurses in all contexts and domains of nursing practice[4] and at all levels of decision-making. It is developed by nurses for nurses and can assist nurses in practising ethically and working through ethical challenges that arise in their practice with individuals, **families**, communities and public health systems.

The societal context in which nurses work is constantly changing and can be a significant influence on their practice. The quality of the work environment in which nurses practise is also fundamental to their ability to practise ethically. The code of ethics is revised periodically (see Appendix A) to ensure that it is attuned to the needs of nurses by reflecting changes in social values and conditions that affect the public, nurses and other **health-care providers**, and the health-care system (see Appendix B for a list of societal changes envisioned to affect nursing practice in the coming decade). Periodic revisions also promote lively dialogue and create greater awareness of and engagement with ethical issues among nurses in Canada.

Purpose of the Code

The *Code of Ethics for Registered Nurses* serves as a foundation for nurses' ethical practice. The specific values and ethical responsibilities expected of registered nurses in Canada are set out in part I. Endeavours that nurses may undertake to address social **inequities** as part of ethical practice are outlined in part II.

---

[1] In this document, the terms *registered nurse* and *nurse* include nurses who are registered or licensed in extended roles, such as nurse practitioners.

[2] In this document, the terms *moral* and *ethical* are used interchangeably based upon consultation with nurse ethicists and philosophers. We acknowledge that not everyone concurs in this usage.

[3] Words or phrases in bold print are found in the glossary. They are shown in bold only on first appearance.

[4] In this document, *nursing practice* refers to all areas of nursing practice, including direct care (which includes community and public health), education, administration, research and policy development.

The code provides guidance for ethical relationships, responsibilities, behaviours and decision-making, and it is to be used in conjunction with the professional standards, laws and regulations that guide practice.

It serves as a means of self-evaluation and self-reflection for ethical nursing practice and provides a basis for feedback and peer review. The code also serves as an ethical basis from which nurses can **advocate** for **quality work environments** that support the delivery of safe, **compassionate**, competent and ethical care.

Nurses recognize the privilege of being part of a self-regulating profession and have a responsibility to merit this privilege. The code informs other health-care professionals as well as members of the public about the ethical commitments of nurses and the responsibilities nurses accept as being part of a self-regulating profession.

Foundation of the Code

Ethical nursing practice involves core ethical responsibilities that nurses are expected to uphold. Nurses are accountable for these ethical responsibilities in their professional relationships with individuals, families, groups, populations, communities and colleagues.

As well, nursing **ethics** is concerned with how broad societal issues affect **health** and **well-being**. This means that nurses endeavour to maintain awareness of aspects of **social justice** that affect health and well-being and to advocate for change. Although these endeavours are not part of nurses' core ethical responsibilities, they are part of ethical practice and serve as a helpful motivational and educational tool for all nurses.

The code is organized in two parts:

PART I: Part I, "Nursing Values and Ethical Responsibilities," describes the core responsibilities central to ethical nursing practice. These ethical responsibilities are articulated through seven primary values and accompanying responsibility statements, which are grounded in nurses' professional relationships with individuals, families, groups, populations and communities as well as with students, colleagues and other health-care professionals. The seven primary values are:

1. Providing safe, compassionate, competent and ethical care
2. Promoting health and well-being
3. Promoting and respecting informed decision-making
4. Preserving dignity
5. Maintaining **privacy** and **confidentiality**
6. Promoting **justice**
7. Being accountable

PART II: Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being. Part II, "Ethical Endeavours," describes endeavours that nurses can undertake to address social inequities.

USING THE CODE IN NURSING PRACTICE

Values are related and overlapping. It is important to work toward keeping in mind all of the values in the code at all times for all persons in order to uphold the dignity of all. In health-care practice, values may be in conflict. Such value conflicts need to be considered carefully in relation to the practice situation. When such conflicts occur, or when nurses need to think through an ethical situation, many find it helpful to use an ethics model for guidance in ethical reflection, questioning and decision-making (see Appendix C).

Nursing practice involves both legal and ethical dimensions. Still, the law and ethics remain distinct. Ideally, a system of law would be completely compatible with the values in this code. However, there may be situations in which nurses need to **collaborate** with others to change a law or policy that is incompatible with ethical practice. When this occurs, the code can guide and support nurses in advocating for changes to law, policy or practice. The code can be a powerful political instrument for nurses when they are concerned about being able to practise ethically.

Nurses are responsible for the ethics of their practice. Given the complexity of ethical situations, the code can only outline nurses' ethical responsibilities and guide nurses in their reflection and decision-making. It cannot ensure ethical practice. For ethical practice, other elements are necessary, such as a commitment to do good; sensitivity and receptiveness to ethical matters; and a willingness to enter into relationships with persons receiving care and with groups, populations and communities that have health-care needs and problems. Practice environments have a significant influence on nurses' ability to be successful in upholding the ethics of their practice. In addition, nurses' self-reflection and dialogue with other nurses and health-care providers are essential components of ethical nursing practice. The importance of the work environment and of reflective practice is highlighted below.

Quality Work Environments

Nurses as individuals and as members of groups advocate for practice settings that maximize the quality of health outcomes for persons receiving care, the health and well-being of nurses, organizational performance and societal outcomes (Registered Nurses' Association of Ontario [RNAO], 2006). Such practice environments have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting. Other health-care providers, organizations and policy-makers at regional, provincial/territorial, national and international levels strongly influence ethical practice.

Nurses' Self-Reflection and Dialogue

Quality work environments are crucial to ethical practice, but they are not enough. Nurses need to recognize that they are **moral agents** in providing care. This means that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care. Nurses in all facets of the profession need to reflect on their practice, on the quality of their interactions with others and on the resources they need to maintain their own well-being. In particular, there is a pressing need for nurses to work with others (i.e., other nurses, other health-care professionals and the public) to create the **moral communities** that enable the provision of safe, compassionate, competent and ethical care.

Nursing ethics encompasses the breadth of issues involved in health-care ethics, but its primary focus is the ethics of the everyday. How nurses attend to ethics in carrying out their daily interactions, including how they approach their practice and reflect on their ethical commitment to the people they serve, is the substance of **everyday ethics**.

In their practice, nurses experience situations involving ethics. The values and responsibility statements in the code are intended to assist nurses in working through these experiences within the context of their unique practice situations.

Types of Ethical Experiences and Situations

When nurses can name the type of ethical concern they are experiencing, they are better able to discuss it with colleagues and supervisors, take steps to address it at an early stage, and receive support and guidance in dealing with it. Identifying an ethical concern can often be a defining moment that allows positive outcomes to emerge from difficult experiences. There are a number of terms that can assist nurses in identifying and reflecting on their ethical experiences and discussing them with others:[5]

Ethical problems involve situations where there are conflicts between one or more values and uncertainty about the correct course of action. Ethical problems involve questions about what is right or good to do at individual, interpersonal, organizational and even societal levels.

Ethical (or moral) uncertainty occurs when a nurse feels indecision or a lack of clarity, or is unable to even know what the moral problem is, while at the same time feeling uneasy or uncomfortable.

Ethical dilemmas or questions arise when there are equally compelling reasons for and against two or more possible courses of action, and where choosing one course of action means that something else is relinquished or let go. True dilemmas are infrequent in health care. More often, there are complex ethical problems with multiple courses of actions from which to choose.

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and **integrity** as moral agents are affected and they feel moral distress.

[5] These situations are derived from CNA, 2004b; Fenton, 1988; Jameton, 1984; and Webster & Baylis, 2000.

Ethical (or moral) residue is what nurses experience when they seriously compromise themselves or allow themselves to be compromised. The moral residue that nurses carry forward from these kinds of situations can help them reflect on what they would do differently in similar situations in the future.

Ethical (or moral) disengagement can occur if nurses begin to see the disregard of their ethical commitments as normal. A nurse may then become apathetic or disengage to the point of being unkind, non-compassionate or even cruel to other health-care workers and to persons receiving care.

Ethical violations involve actions or failures to act that breach fundamental duties to the persons receiving care or to colleagues and other health-care providers.

Ethical (or moral) courage is exercised when a nurse stands firm on a point of moral principle or a particular decision about something in the face of overwhelming fear or threat to himself or herself.

PART I: NURSING VALUES AND ETHICAL RESPONSIBILITIES

Nurses in all domains of practice bear the ethical responsibilities identified under each of the seven primary nursing values.[6] These responsibilities apply to nurses' interactions with individuals, families, groups, populations, communities and society as well as with students, colleagues and other health-care professionals. The responsibilities are intended to help nurses apply the code. They also serve to articulate nursing values to employers, other health-care professionals and the public. Nurses help their colleagues implement the code, and they ensure that student nurses are acquainted with the code.

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care as well as with families, communities, groups, populations and other members of the **health-care team**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

3. Nurses build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people's needs and concerns.

[6] The value and responsibility statements in the code are numbered and lettered for ease of use, not to indicate prioritization. The values are related and overlapping..

4. Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. See Appendix D.

5. Nurses admit mistakes[7] and take all necessary actions to prevent or minimize harm arising from an **adverse event**. They work with others to reduce the potential for future risks and preventable harms. See Appendix D.

6. When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care, families and employers informed about potential and actual changes to delivery of care. They inform employers about potential threats to safety.

7. Nurses planning to take job action or practising in environments where job action occurs take steps to safeguard the health and safety of people during the course of the job action. See Appendix D.

8. During a natural or human-made disaster, including a communicable disease outbreak, nurses have a **duty to provide care** using appropriate safety precautions. See Appendix D.

9. Nurses support, use and engage in research and other activities that promote safe, competent, compassionate and ethical care, and they use guidelines for ethical research[8] that are in keeping with nursing values.

10. Nurses work to prevent and minimize all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk to protect others and themselves.

---

[7] Provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting.

[8] See *Ethical Research Guidelines for Registered Nurses* (CNA, 2002) and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 1998).

B. Promoting Health and Well-Being

Nurses work with people to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of the person, family or community in their care.
2. When a community health intervention interferes with the individual rights of persons receiving care, nurses use and advocate for the use of the least restrictive measures possible for those in their care.
3. Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons receiving care and those with health-care needs, recognizing and respecting the knowledge, skills and perspectives of all.

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical responsibilities:

1. Nurses, to the extent possible, provide persons in their care with the information they need to make informed decisions related to their health and well-being. They also work to ensure that health information is given to individuals, families, groups, populations and communities in their care in an open, accurate and transparent manner.

2. Nurses respect the wishes of **capable** persons to decline to receive information about their health condition.

3. Nurses recognize that capable persons may place a different weight on individualism and may choose to defer to family or community values in decision-making.

4. Nurses ensure that nursing care is provided with the person's **informed consent**. Nurses recognize and support a capable person's right to refuse or withdraw **consent** for care or treatment at any time.

5. Nurses are sensitive to the inherent power differentials between care providers and those receiving care. They do not misuse that power to influence decision-making.

6. Nurses advocate for persons in their care if they believe that the health of those persons is being compromised by factors beyond their control, including the decision-making of others.

7. When family members disagree with the decisions made by a person with health-care needs, nurses assist families in gaining an understanding of the person's decisions.

8. Nurses respect the informed decision-making of capable persons, including choice of lifestyles or treatment not conducive to good health.

9. When illness or other factors reduce a person's capacity for making choices, nurses assist or support that person's participation in making choices appropriate to their capability.

10. If a person receiving care is clearly **incapable** of consent, the nurse respects the law on capacity assessment and substitute decision-making in his or her jurisdiction (Canadian Nurses Protective Society [CNPS], 2004).

11. Nurses, along with other health-care professionals and with **substitute decision-makers**, consider and respect the best interests of the person receiving care and any previously known wishes or **advance directives** that apply in the situation (CNPS, 2004).

D. Preserving Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons with respect.
2. Nurses support the person, family, group, population or community receiving care in maintaining their dignity and integrity.
3. In health-care decision-making, in treatment and in care, nurses work with persons receiving care, including families, groups, populations and communities, to take into account their unique values, customs and spiritual beliefs, as well as their social and economic circumstances.
4. Nurses intervene, and report when necessary,[9] when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour. See Appendix D.
5. Nurses respect the physical privacy of persons by providing care in a discreet manner and by minimizing intrusions.
6. When providing care, nurses utilize practice standards, best practice guidelines and policies concerning restraint usage.
7. Nurses maintain appropriate professional **boundaries** and ensure their relationships are always for the benefit of the persons they serve. They recognize the potential vulnerability of persons and do not exploit their trust and dependency in a way that might compromise the therapeutic relationship. They do not abuse their relationship for personal or financial gain, and do not enter into personal relationships (romantic, sexual or other) with persons in their care.

[9] See footnote 7.

8. In all practice settings, nurses work to relieve pain and suffering, including appropriate and effective symptom and pain management, to allow persons to live with dignity.

9. When a person receiving care is terminally ill or dying, nurses foster comfort, alleviate suffering, advocate for adequate relief of discomfort and pain and support a dignified and peaceful death. This includes support for the family during and following the death, and care of the person's body after death.

10. Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way. See Appendix D.

E. Maintaining Privacy and Confidentiality

Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

Ethical responsibilities:

1. Nurses respect the right of people to have control over the collection, use, access and disclosure of their personal information.
2. When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard.
3. Nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with privacy laws.
4. When nurses are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the individual, family or community.
5. When nurses engage in any form of communication, including verbal or electronic, involving a discussion of clinical cases, they ensure that their discussion of persons receiving care is respectful and does not identify those persons unless appropriate.
6. Nurses advocate for persons in their care to receive access to their own health-care records through a timely and affordable process when such access is requested.
7. Nurses respect policies that protect and preserve people's privacy, including security safeguards in information technology.

8. Nurses do not abuse their access to information by accessing health-care records, including their own, a family member's or any other person's, for purposes inconsistent with their professional obligations.

9. Nurses do not use photo or other technology to intrude into the privacy of a person receiving care.

10. Nurses intervene if others inappropriately access or disclose personal or health information of persons receiving care.

F. Promoting Justice

Nurses uphold principles of justice by safeguarding **human rights**, equity and **fairness** and by promoting the public good.

Ethical responsibilities:

1. When providing care, nurses do not discriminate on the basis of a person's race, ethnicity, **culture**, political and spiritual beliefs, social or marital status, gender, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability or socio-economic status or any other attribute.

2. Nurses refrain from judging, labelling, demeaning, stigmatizing and humiliating behaviours toward persons receiving care, other health-care professionals and each other.

3. Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours.

4. Nurses make fair decisions about the allocation of resources under their control based on the needs of persons, groups or communities to whom they are providing care. They advocate for fair treatment and for fair distribution of resources for those in their care.

5. Nurses support a climate of trust that sponsors openness, encourages questioning the status quo and supports those who speak out to address concerns in good faith (e.g., **whistle-blowing**).

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice.

2. Nurses are honest and practise with integrity in all of their professional interactions.

3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, seek help from their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

4. Nurses maintain their **fitness to practise**. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self-employed, arranging that someone else attend to their clients' health-care needs. Nurses then take the necessary steps to regain their fitness to practise.

5. Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. See Appendix D.

6. Nurses clearly and accurately represent themselves with respect to their name, title and role.

7. If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made. See Appendix D.

8. Nurses identify and address conflicts of interest. They disclose actual or potential conflicts of interest that arise in their professional roles and relationships and resolve them in the interest of persons receiving care.

9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members. See Appendix D.

PART II: ETHICAL ENDEAVOURS

There are broad aspects of social justice that are associated with health and well-being and that ethical nursing practice addresses. These aspects relate to the need for change in systems and societal structures in order to create greater **equity** for all. Nurses should endeavour as much as possible, individually and collectively, to advocate for and work toward eliminating social inequities by:

i. Utilizing the principles of **primary health care** for the benefit of the public and persons receiving care.

ii. Recognizing and working to address organizational, social, economic and political factors that influence health and well-being within the context of nurses' role in the delivery of care.

iii. In collaboration with other health-care team members and professional organizations, advocating for changes to unethical health and social policies, legislation and regulations.

iv. Advocating for a full continuum of accessible health-care services to be provided at the right time and in the right place. This continuum includes **health promotion**, disease prevention and diagnostic, restorative, rehabilitative and palliative care services in hospitals, nursing homes, home care and the community.

v. Recognizing the significance of **social determinants of health** and advocating for policies and programs that address these determinants.

vi. Supporting environmental preservation and restoration and advocating for initiatives that reduce environmentally harmful practices in order to promote health and well-being.

vii. Working with individuals, families, groups, populations and communities to expand the range of health-care choices available, recognizing that some people have limited choices because of social, economic, geographic or other factors that lead to inequities.

viii. Understanding that some groups in society are systemically disadvantaged, which leads to diminished health and well-being. Nurses work to improve the quality of lives of people who are part of disadvantaged and/or **vulnerable groups** and communities, and they take action to overcome barriers to health care.

ix. Advocating for health-care systems that ensure accessibility, universality and comprehensiveness of necessary health-care services.

x. Maintaining awareness of major health concerns such as poverty, inadequate shelter, food insecurity and violence. Nurses work individually and with others for social justice and to advocate for laws, policies and procedures designed to bring about equity.

xi. Maintaining awareness of broader **global health** concerns such as violations of human rights, war, world hunger, gender inequities and environmental pollution. Nurses work individually and with others to bring about social change.

xii. Advocating for the discussion of ethical issues among health-care team members, persons in their care, families and students. Nurses encourage ethical reflection, and they work to develop their own and others' heightened awareness of ethics in practice. See Appendix C.

xiii. Working collaboratively to develop a moral community. As part of the moral community, all nurses acknowledge their responsibility to contribute to positive, healthy work environments.

GLOSSARY

The glossary is intended to provide nurses with a common language for their reflections and discussions about nursing ethics. It may also be instructive, since nurses who read the glossary terms are more likely to investigate these concepts further, especially if they are unfamiliar. The glossary does not necessarily provide formal definitions of terms, but rather it presents information in a manner and language that is meant to be helpful and accessible. Some terms in the glossary are not included in the main body of the code but are in the appendices, others may not appear exactly as noted in the text, and others may not be included in the text but may be useful to nurses in their ethical reflection and practice.

ADVANCE DIRECTIVES: a person's written wishes about how and what decisions should be made if they become incapable of making decisions for themselves. In decisions about life-sustaining treatment, advance directives are meant to assist with decisions about withholding or withdrawing treatment. Also called living wills or personal directives.

ADVERSE EVENTS: unexpected, undesirable incidents resulting in injury or death that are directly associated with the process of providing health care or health services to a person receiving care (Hebert, Hoffman & Davies, 2003).

ADVOCATE: actively supporting a right and good cause; supporting others in speaking for themselves or speaking on behalf of those who cannot speak for themselves

BOUNDARIES: a boundary in the nurse-person relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal (College and Association of Registered Nurses of Alberta [CARNA], 2005a).

CAPABLE: being able to understand and appreciate the consequences of various options and make informed decisions about one's own care and treatment.

COLLABORATE: building consensus and working together on common goals, processes and outcomes (RNAO, 2006).

COMPASSIONATE: the ability to convey in speech and body language the hope and intent to relieve the suffering of another. Compassion must coexist with competence. "Compassion is a relational process that involves noticing another person's pain, experiencing an emotional reaction to his or her pain, and acting in some way to help ease or alleviate the pain" (Dutton, Lilius & Kanov, 2007).

COMPETENCY: the integrated knowledge, skills, judgment and attributes required of a registered nurse to practise safely and ethically in a designated role and setting. (Attributes include, but are not limited to, attitudes, values and beliefs.)

CONFIDENTIALITY: the ethical obligation to keep someone's personal and private information secret or private (Fry & Johnstone, 2002).

CONFLICT OF INTEREST: occurs when a nurse's personal or private interests interfere with the interests of a person receiving care or with the nurse's own professional responsibilities (College of Registered Nurses of British Columbia [CRNBC], 2006c).

CONSENT: *See Informed consent.*

CONSCIENTIOUS OBJECTION: a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs (CRNBC, 2007).

CULTURES: the processes that happen between individuals and groups within organizations and society, and that confer meaning and significance; the health-care system has its own culture(s) (Varcoe & Rodney, 2002).

DETERMINANTS OF HEALTH: these include income and social status, social support, education and literacy, employment and working conditions, physical and social environments, biology, genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture (Public Health Agency of Canada, 2003).

DIVERSITY: the variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class or life experiences (RNAO, 2007a).

DUTY TO PROVIDE CARE: Nurses have a professional duty and a legal obligation to provide persons receiving care with safe, competent, compassionate and ethical care. There may be some circumstances in which it is acceptable for a nurse to withdraw from care provisions or to refuse to provide care (CRNBC, 2007; College of Registered Nurses of Nova Scotia [CRNNS], 2006a). See Appendix D.

EQUITABLE: determining fairness on the basis of people's needs.

EQUITY: in health care, the fulfillment of each individual's needs as well as the individual's opportunity to reach full potential as a human being (Canadian Nurses Association [CNA], 2006).

ETHICS: the moral practices, beliefs and standards of individuals and/or groups (Fry & Johnstone, 2002).

EVERYDAY ETHICS: how nurses pay attention to ethics in carrying out their common daily interactions, including how they approach their practice and reflect on their ethical commitments to persons receiving care and those with health-care needs.

FAIRNESS: equalizing people's opportunities to participate in and enjoy life, given their circumstances (Caplan, Light & Daniels, 1999), and society's equitable distribution of resources (in health care this means an expectation of equitable treatment).

FAMILY/FAMILIES: In matters of caregiving, family is recognized to be those people identified by the person receiving care or in need of care as providing familial support, whether or not there is a biologic relationship. However, in matters of legal decision-making it must be noted that provincial legislation is not uniform across Canada and may include an obligation to recognize family members in priority according to their biologic relationship (CNA, 1994).

FITNESS TO PRACTISE: all the qualities and capabilities of an individual relevant to his or her capacity to practise as a registered nurse, including, but not limited to, freedom from any cognitive, physical, psychological or emotional condition and dependence on alcohol or drugs that impairs his or her ability to practise nursing (CRNBC, 2006a; CRNNS, 2006b).

GLOBAL HEALTH: the optimal well-being of all humans from the individual and the collective perspective. Health is considered a fundamental right and should be equally accessible by all (CNA, 2003).

HEALTH: a state of complete physical, mental (spiritual) and social well-being, not merely the absence of disease (CNA, 2007; World Health Organization [WHO], 2006).

HEALTH-CARE PROVIDERS: all those who are involved in providing care; they may include professionals, personal care attendants, home support workers and others (CNA, 1994).

HEALTH-CARE TEAM: a number of health-care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with individuals, families, groups, populations or communities.

HEALTH PROMOTION: a continuing process of enabling people to increase their control over and improve their health and well-being.

HUMAN RIGHTS: the rights of people as expressed in the *Canadian Charter of Rights and Freedoms* (1982) and the *United Nations Universal Declaration of Human Rights* (1948), and as recorded in the CNA position statement *Registered Nurses and Human Rights* (CNA, 2004a).

INCAPABLE/INCAPACITY: failing to understand the nature of the treatment decisions to be made, as well as the consequences of consenting to treatment or declining treatment.

INEQUITY: an instance of unjust or unfair treatment of each individual's needs; health inequity means a lack of equitable access and opportunity for all people to meet their health needs and potential (CNA, 2006).

INFORMED CONSENT: the process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research. In the code, the term *informed decision-making* is primarily used to emphasize the choice involved.

INTEGRITY: (1) for persons receiving care, integrity refers to wholeness, and protecting integrity can mean helping them to become whole and complete again; (2) for health-care providers, showing integrity means consistently following accepted moral norms. Implicit in integrity is soundness, trustworthiness and consistency of convictions, actions and emotions (Burkhart & Nathaniel, 2002).

INTERDISCIPLINARY: the integration of concepts across different disciplines. An interdisciplinary team is a team of people with training in different fields: such teams are common in complex environments such as health care (RNAO, 2007b) and may also be referred to as interprofessional teams.

INTERSECTORAL: all sectors of society (government, community and health).

JUSTICE: includes respecting the rights of others, distributing resources fairly, and preserving and promoting the common good (the good of the community).

MORAL AGENT/AGENCY: the capacity or power of a nurse to direct his or her motives and actions to some ethical end; essentially, doing what is good and right.

MORAL CLIMATE: in health care, the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered (Rodney, Hartrick Doane, Storch & Varcoe, 2006).

MORAL COMMUNITY: a workplace where values are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard (adapted from Rodney & Street, 2004). Coherence between publicly professed values and the lived reality is necessary for there to be a genuine moral community (Webster & Baylis, 2000).

NURSE(S): in this code, refers to registered nurses, including nurses in extended roles such as nurse practitioners.

PERSON/PERSONS RECEIVING CARE: an individual, family, group, community or population that accesses the services of the registered nurse; may also be referred to as client(s) or patient(s).

PRIMARY HEALTH CARE: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (WHO, 1978).

PRIVACY: (1) physical privacy is the right or interest in controlling or limiting the access of others to oneself; (2) informational privacy is the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared.

PUBLIC GOOD: the good of society or the community, often called the common good.

QUALITY PRACTICE ENVIRONMENTS: practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care (CNA, 2001).

SOCIAL DETERMINANTS OF HEALTH: factors in the social environment, external to the health-care system, that exert a major and potentially modifiable influence on the health of populations (Evans, 1994). See also *Determinants of health.*

SOCIAL JUSTICE: the fair distribution of society's benefits and responsibilities and their consequences. It focuses on the relative position of one social group in relation to others in society as well as on the root causes of disparities and what can be done to eliminate them (CNA, 2006).

SUBSTITUTE DECISION-MAKER: an individual designated by operation of a provincial or territorial statute or in an advance directive of a person in care to make decisions about health care and treatment on the person's behalf (CNA, 1994).

UNREGULATED CARE PROVIDER: paid providers who are neither licensed nor registered by a regulatory body (CRNBC, 2006b).

VALUES: standards or qualities that are esteemed, desired, considered important or have worth or merit (Fry & Johnstone, 2002).

VIOLENCE: includes any abuse of power, manipulation or control of one person over another that could result in mental, emotional, social or physical harm.

VULNERABLE GROUPS: groups disadvantaged by attitudes and systems in society that create inequities.

WELL-BEING: a person's state of being well, content and able to make the most of his or her abilities.

WHISTLE-BLOWING: speaking out about unsafe or questionable practices affecting people receiving care or working conditions. This should be resorted to only after a person has unsuccessfully used all appropriate organizational channels to right a wrong and has a sound moral justification for taking this action (Burkhardt & Nathaniel, 2002).

APPENDICES

Appendix A: **The History of the Canadian Nurses Association Code of Ethics**

Appendix B: **Context of the Code**

Appendix C: **Ethical Models**

- An Ethical Model for Reflection: Questions to Consider
- Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications

Appendix D: **Applying the Code in Selected Circumstances**

- Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care
- Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience
- Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic
- Ethical Considerations in Relationships with Nursing Students
- Acting Ethically in Situations That Involve Job Action

APPENDIX A: The History of the Canadian Nurses Association Code of Ethics

1954	CNA adopts the International Council of Nurses' code as its first code of ethics
1980	CNA adopts its own code, entitled *CNA Code of Ethics: An Ethical Basis for Nursing in Canada*
1985	CNA adopts a new code, called *Code of Ethics for Nursing*
1991	*Code of Ethics for Nursing* revised
1997	*Code of Ethics for Registered Nurses* adopted as the updated code of CNA
2002	*Code of Ethics for Registered Nurses* revised
2008	*Code of Ethics for Registered Nurses* revised

The CNA *Code of Ethics for Registered Nurses* is not based on a particular philosophy or ethical theory but arises from different schools of thought, including relational ethics, an ethic of care, principle-based ethics, feminist ethics, virtue ethics and values. It has been developed over time by nurses for nurses, and it therefore continues to have a practical orientation supported by theoretical diversity.

CNA prepares position papers, practice papers on specific ethics issues, booklets and other ethics-related resources, and it maintains an electronic mailing list that provides a forum for dialogue on ethics in nursing. In addition, CNA works with other health professional associations and colleges to develop interprofessional statements (e.g., about no-resuscitation policies) related to issues or concerns of an ethical nature.

APPENDIX B: CONTEXT OF THE CODE

The Canadian Nurses Association's *Code of Ethics for Registered Nurses* is revised periodically to reflect changes that affect the public, nurses, other health-care providers and the health-care system and that create both new challenges and opportunities for nursing practice. Examples[10] of changes currently occurring, as well as those envisioned in the coming decade, can be found below:

Challenges and opportunities affecting the public

- Greater public access to health information from a variety of formal and informal sources
- Increased public use of alternative and complementary therapies
- Increasing health-care expectations by some persons who are receiving care, and increasing disenfranchisement of others who are having difficulty accessing care
- Continued and escalating societal expectations that people will practise self-care
- Increasing societal expectations that families and communities will "look after their own"
- Individual or family isolation in the provision of self-care or care for a family member
- Widening and deepening local, regional and global inequities in health and social resources and in access to health care based upon gender, class and race

[10] Reference to these contextual realities are found in the following documents: Government of Canada. (2002). *Building on values: The future of health care in Canada – Final report.* Ottawa: Commission on the Future of Health Care in Canada; Health Canada. (2002). *Our health, our future. Creating quality workplaces for Canadian nurses. Final report of the Canadian nursing advisory committee.* Ottawa: Author; Canadian Health Services Foundation. (2006). *What's ailing our nurses?* Ottawa: Author; Canadian Health Services Research Foundation. (2006). *Staffing for safety.* Ottawa: Author; Villeneuve, M., & MacDonald, J. (2006). *Toward 2020: Visions for nursing.* Ottawa: Canadian Nurses Association; Torgerson, R. (2007). *Not there yet: Improving the working conditions of Canadian nurses.* Ottawa: Canadian Policy Research Networks; UNESCO International Bioethics Committee (ICB). (2007). *Preliminary draft report of the IBC working group on social responsibility and health.* Retrieved on February 22, 2008, from http://unesdoc.unesco.org/images/0015/001505/150522e.pdf

- Demographic shift as baby boomers age and the very old live longer, resulting in increasing numbers of people who require complex health care
- Increasing rates of chronic illness and lack of accessible social supports
- Greater recognition that pain and suffering are underdiagnosed and undertreated
- New and emerging infectious disease
- Increasing rates of infections that originate in hospitals or similar settings (health-care acquired infections) and an increased awareness of other care-related injury and harms
- Threats of natural and human-made disasters, pandemics and bioterrorism
- Continued presence of war, human trafficking and racial tensions

Challenges and opportunities affecting nurses and other health-care providers

- Increasing **diversity** in the populations of people receiving care
- Increasing diversity among health-care professionals and other health-care providers
- A continuing and worsening shortage of nurses and shortage of all health-care professionals and allied health-care providers
- Shortages of clinical support workers with related increasing demands on nurses to do additional non-nursing work so that safe patient care is maintained
- Excessive hours of work and work overload with associated increases in nurse injury, illness and turnover of nursing staff

- Nurse staffing deficiencies that are associated with increased rates of morbidity and mortality among persons receiving care, as demonstrated in research-based findings
- Limited numbers of well-prepared managers to lead the development of healthy work environments and effective nurse retention strategies
- Broader and evolving scopes of practice for nurses and other health-care providers
- Increased numbers of complex **intersectoral** health-care teams that include other health-care professionals and **unregulated workers**
- Increased requirements for well-functioning, innovative health-care teams as a result of the changing roles and scopes of practice of registered nurses and other health-care providers
- Emerging challenges for nurses with regard to potential situations of **conflict of interest** (e.g., relationships with pharmaceutical companies) as roles evolve to broader scopes of practice
- A growing cadre of nurses involved in conducting and participating in research to develop and use evidence-based guidelines and other knowledge for nursing practice and health

Challenges within the socio-political context of the health-care system

- Increasing disparity between resources for urban and rural health-care centres
- Increasing need for health promotion and prevention (primary care), including mental health
- Ongoing tension between individual good and the **public good**

- Ongoing debate within Canadian society over the acceptable amount and mix of public and private interests in the financing and delivery of health care
- Ongoing challenges to preserving an adequately publicly funded, universal and accessible health-care system that equitably serves health-care needs across the continuum of care
- Difficult choices in the allocation of resources, program and services
- Increasing recognition that social inequities drive health-care decision-making and health-care inequities
- A sense that financial gain by health-care agencies and health-care providers in public and private health-care delivery may be influencing health-care decisions (e.g., early discharge of people from hospitals)
- Shorter hospital stays and increased reliance on home and community care and self-care
- Increase in the complexity of care needed in all settings and lack of accessible social supports for people needing care and their families
- Rapid introduction of new technology and pharmaceutical drugs
- Advances in genetics and genomics
- Greater expectations of the public to have access to new technology with the sometimes unfounded expectation that new technology will lead to better health outcomes
- Increasing use of information technology and electronically stored health data in the health-care system
- An accelerating trend toward public-private sector delivery and information systems that increase potential risks to the privacy of persons receiving care

- Rise in the number of policies and legislation related to access to private information
- Increased emphasis on safety and on developing a just culture in health care, in which individuals, organizations and health-care systems share accountability for reducing risks and preventing avoidable harms
- Proliferation of research findings in health care that need to be impartially assessed to determine the quality of evidence
- Ongoing tensions between preserving scientific integrity and maximizing commercial interests in the research and development of health-care technologies and therapies
- Pressing need to understand the relations between human health and environmental health (e.g., global warming) and to act on issues related to the environment on which health depends

APPENDIX C: ETHICAL MODELS

An Ethical Model for Reflection: Questions to Consider

The code points to the need for nurses to engage in ethical reflection and discussion. Frameworks or models can help people order their approach to an ethical problem or concern, and they can be a useful tool to guide nurses in their thinking about a particular issue or question.

When it is appropriate, colleagues in nursing and other disciplines, ethics committees, ethicists, professional nurses associations and colleges of registered nurses and other experts should be included in discussions of ethical problems. Legislation, standards of practice, policies and guidelines of nurses' unions and professional associations and colleges may also be useful in ethical reflection and decision-making.

Ethical reflection (which begins with a review of one's own ethics) and judgment are required to determine how a particular value or responsibility applies in a particular nursing context. There is room within the profession for disagreement among nurses about the relative weight of different ethical values and principles. More than one proposed intervention may be ethical and reflective of good ethical practice. Discussion and questioning are extremely helpful in the resolution of ethical problems and issues.

Ethical models also facilitate discussion among team members by opening up a moral space for everyone to participate in the conversation about ethics. There are many models for ethical reflection and for ethical decision-making in the health-care ethics literature, and some of these are noted in this section. The model provided here[11] was selected because it offers a nursing model for considering ethics issues in practice, promotes reflection and is applicable to all types of ethical situations.

[11] This model is adapted from *Nursing Ethics in Canadian Practice* by Oberle & Raffin (in press).

Oberle & Raffin Model

1. ***Understanding the ethics of the situation: Relationships, goals, beliefs and values***

   In reflecting on what will best fulfil the goal of improving a person's well-being, nurses must first *want* to do good. They clarify their own values as well as the values in the code of ethics that apply to a given situation. They ask some of the following questions:

   - What are my own values in this situation?
   - What are the values of all those involved?
   - What are the goals people hope to achieve?
   - What do others consider to be a good outcome?
   - What is the level of knowledge of the persons receiving care or in need of care?
   - What information do they need?
   - What are the relationships within the family of the person receiving care or in need of care and between the family and health-care providers?
   - What value differences exist among the caregivers and those receiving care or in need of care?

2. ***Reflecting on the range of available choices***

   When reflecting on possible choices, nurses ask:

   - What will help individuals and families clarify what they think will do the most good for their situation?
   - What do other health-care providers think is best?
   - What might be the effects of the various choices?
   - What values would society consider appropriate in this situation?

- What economic, political, legal, institutional and cultural factors are at play in the person's health situation?
- What options require further information and discussion?

3. ***Maximizing the good***

Nurses try to act in accordance with the capable person's expressed desires. Questions that need to be asked to achieve this end are the following:

- Will what the individual desires conflict with the good of other individuals or of the community?
- Can ways be found to respect the wishes of the person receiving care or in need of care, while keeping the needs of others in mind?
- What might prevent nurses from taking an ethical action?
- Will taking action in this situation require moral courage?
- Will the nurses and other health-care providers be supported in taking action?

4. ***Taking ethical action***

Before taking action, nurses reflect on how that action fits with the code of ethics and whether it is what a reasonably prudent and ethical nurse would do in this situation. They assess their ability to act with care and compassion and to meet their professional and institutional expectations.

5. ***Reflecting on and reviewing an ethical action***

In reviewing and reflecting on their actions, nurses consider both the process and outcome. They ask if the situation was handled in the best way possible, including both *how* things were done as well as *what* was done. They also consider how everyone involved in the situation was affected, and whether harm was minimized and a good choice was found.

Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications

Several other models for ethical reflection and decision-making are in common use. Nurses find that some models are helpful in particular areas of practice (e.g., in acute care practice, long-term care, public health) and that some models are more meaningful to them than others.

Many models include the four principles of biomedical ethics – autonomy, beneficence, nonmaleficence and justice – which some nurses find practical because these models may bridge biomedical and nursing ethics in acute care. Some nurses prefer a model that offers a diagram rather than text: examples of diagram models are the Bergum and the Storch models (CARNA, 2005b). Others prefer an algorithm, such as the one developed by Matthews (2007), and still others prefer a more philosophically based model, such as that offered by Yeo and Moorhouse (1996).

A few key sources are listed below. The first source is likely the most comprehensive, since it analyzes cases using three models.

- CNA's ***Everyday Ethics: Putting the Code into Practice*** (2nd ed.) (2004b) is a study guide to help nurses use the CNA code of ethics and reflect on ethical practice. It offers three models: "A Guide for Moral Decision-Making" (developed by Chris McDonald), "The Four Topics Method" (by Jonsen, Siegler & Winslade, 1997) and "The Circle Method for Ethical Decision-Making" (by Jan Storch), with examples of their application to practice. Numerous other models are listed and briefly described in the appendix to this study guide.
- CARNA published ***Ethical Decision-Making for Registered Nurses in Alberta: Guidelines and Recommendations*** in 2005. Included in CARNA's paper is the Bergum model for questioning (in the image of a flower) and a full case analysis using the Bergum model.

- The ***Framework for Ethical Decision-Making,*** developed by Michael McDonald with additions provided by Patricia Rodney and Rosalie Starzomski, provides detailed questions to consider in ethical decision-making. It is available from www.ethics.ubc.ca/people/mcdonald/decisions.htm

- ***Nursing Ethics: Cases and Concepts*** (1996) by M. Yeo & A. Moorhouse. These authors provide a way to think through ethical problems using three types of analysis (descriptive, conceptual and normative).

- ***Nursing ethics decision-making algorithm*** developed by J. Matthews at Brock University (included in the ethics resources on the CNA website).

APPENDIX D:
Applying the Code in Selected Circumstances

Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care

> *Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. (Code, A4)*
>
> *Nurses admit mistakes[12] and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms. (Code, A5)*
>
> *Nurses intervene, and report when necessary,[13] when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour. (Code, D4)*
>
> *Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the* Code of Ethics for Registered Nurses *and in keeping with the professional standards, laws and regulations supporting ethical practice. (Code, G1)*
>
> *Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. (Code, G5)*

If a nurse encounters a situation where harm is underway or there is a clear risk of imminent harm, he or she should take immediate steps to protect the safety and dignity of the persons receiving care. Some examples

[12] See footnote 7.

[13] See footnote 7.

of appropriate immediate steps in cases of actual or imminent harm could include, but are not limited to, speaking up if a potential error in drug calculations is detected, questioning an unclear order, intervening to prevent unsafe restraint practices, protecting patients when a colleague's performance appears to be impaired for any reason (see CRNNS, 2006b) or interfering with a serious breach of confidentiality involving people with sexually transmitted infections. Nurses should be aware of provincial and territorial legislation and nursing practice standards that may include direction regarding disclosure and reporting and provide further clarity on whether there is a clear risk of imminent harm.

When nurses encounter situations where harm is not imminent but there is potential for harm, they work to resolve the problem as directly as possible in ways that are consistent with the good of all parties. As they work through these situations, nurses review relevant statements in the *Code of Ethics for Registered Nurses* and other relevant standards, legislation, ethical guidelines, policies and procedures for reporting incidents or suspected incompetent or unethical care, including any legally reportable offence.

Some additional actions for nurses to consider, if they do not contravene requirements under professional standards or provincial or territorial legislation, include:

- Maintain a high level of confidentiality about the situation and actions at all times.
- Review all information available about the current situation. Separate personal from professional issues. Concentrate on the situation at hand.
- Where appropriate and feasible, seek information directly from the colleague(s) whose behaviour or practice has raised concerns.
- Pay attention to the moral distress nurses are experiencing in trying to find an ethical course of action. Consider the risks of not taking action to persons receiving care, colleagues, self, and the organization, and reflect on the potential harms and breaches in trust that

could result if no action is taken. Nurses need to consider as well the consequences that may occur for them and for others in taking various courses of action.

- If possible, speak with an impartial and trusted colleague outside of the situation who can preserve appropriate confidential information and help validate or rule out the conclusions being drawn.
- Seek information from relevant authorities (e.g., supervisor or manager) on expected roles and responsibilities for all of the parties who share responsibility for maintaining safe, competent, compassionate and ethical care.
- Consult, as appropriate, with colleagues, other members of the team, professional nursing associations or colleges or others who are able to assist in addressing and resolving the problem.
- Advise the appropriate parties regarding unresolved concerns and, when feasible, inform the colleague(s) in question of the reasons for your action. Know what immediate help is available to colleague(s) and be ready to help the colleague(s) find these resources.

Nurses who engage in responsible reporting of incompetent, unsafe or unethical care should be supported by their colleagues, professional association and/or professional college.

Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience

Nurses are not at liberty to abandon those in need of nursing care. However, nurses may sometimes be opposed to certain procedures and practices in health care and find it difficult to willingly participate in providing care that others have judged to be morally acceptable. The nurse's right to follow his or her conscience in such situations is recognized by CNA in the *Code of Ethics for Registered Nurses* in its provision for **conscientious objection**.

If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made. (Code, G7)

Steps in Declaring a Conflict with Conscience (American Nurses Association [ANA], 2006; Registered College of Nurses, Australia [RCNA], 2000)

1. Before employment

Nurses have a moral responsibility to advise their prospective employer if they are conscientiously opposed to certain practices and procedures that are likely to occur in their prospective workplace, particularly if the expression of conflict of conscience "would significantly interfere with the provision of services offered by the employing agency" (RCNA, 2000, p. 1). Similarly, employers should advise prospective employees about services provided by the organization that may be sensitive for some employees.

2. Anticipating and planning to declare a conflict with conscience

Ideally, the nurse would be able to anticipate practices and procedures that would create a conflict with his or her conscience (beliefs and values) in advance. In this case, the nurse should discuss with supervisors, employers or, when the nurse is self-employed, persons receiving care what types of care she or he finds contrary to his or her own beliefs and values (e.g., caring for individuals having an abortion, male circumcision, blood transfusion, organ transplantation) and request that his or her objections be accommodated, unless it is an emergency situation.

Ideally, nurses in positions of formal leadership would ensure that workplaces have a policy in place to deal with matters of conscience so that a nurse can be exempt from participating in procedures he or she considers morally objectionable without being penalized.

3. Finding oneself caught in providing care that is in conflict with one's conscience

When a nurse finds herself or himself involved in nursing care that creates a conflict with her or his conscience, he or she should notify the supervisor, employer or, if she or he is self-employed, the persons receiving care. Declaring a conflict with conscience, or "conscientious objection," and requesting accommodation is a serious matter that is not to be taken lightly. In all cases, the nurse remains until another nurse or health-care provider is able to provide appropriate care to meet the person's needs.

Key guidelines with respect to a declaration of a conflict with conscience include the following:

1. The nurse who decides not to take part in providing care on the grounds of moral objection communicates his or her desires in appropriate ways.
2. Whenever possible such refusal is made known in advance and in time for alternative arrangements to be made for persons receiving care.
3. Moral objections by the nurse are motivated by moral concerns and an informed, reflective choice and are not based upon prejudice, fear or convenience.
4. When a moral objection is made, the nurse provides for the safety of the person receiving care until there is assurance that other sources of nursing care are available.

5. Employers and co-workers are responsible for ensuring that nurses and other co-workers who declare a conflict of conscience receive fair treatment and do not experience discrimination (RCNA, 2000, p.2).

6. Nurses need to be aware that declaring a conflict of conscience may not protect them against formal or informal penalty.

Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic

Historically and currently, nurses provide care to those in need, even when providing care puts their own health and life at risk (for example, when they work in war-torn areas, places of poverty, in places with poor sanitation, etc.). Nurses also encounter personal risk when providing care for those with known or unknown communicable or infectious disease. However, disasters and communicable disease outbreaks call for extraordinary effort from all health-care personnel, including registered nurses. The code states:

> *During a natural or human-made disaster, including a communicable disease outbreak, nurses have a duty to provide care using appropriate safety precautions. (Code, A8)*

A duty to provide care refers to a nurse's professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care. However, there may be some circumstances in which it is acceptable for a nurse to withdraw from providing care or to refuse to provide care (CRNBC, 2007; CRNNS, 2006a). Unreasonable burden is a concept raised in relation to the duty to provide care and withdrawing from providing or refusing to provide care. An unreasonable burden may exist when a nurse's ability to provide safe care and meet professional standards of practice is compromised by unreasonable expectations, lack of resources or ongoing threats to personal well-being (CRNBC, 2007).

The following criteria could be useful for nurses to consider when contemplating their obligation to provide care in a disaster or communicable disease outbreak:

- the significance of the risk to the person in care if the nurse does not assist;
- whether the nurse's intervention is directly relevant to preventing harm;
- whether the nurses' care will probably prevent harm; and
- whether the benefit of the nurse's intervention outweighs harms the nurse might incur and does not present more than an acceptable risk to the nurse (ANA, 2006).

When demands on the health-care system are excessive, material resources may be in short supply and nurses and other health-care providers may be at risk. Nurses have a right to receive truthful and complete information so that they can fulfil their duty to provide care. They must also be supported in meeting their own health needs. Nurses' employers have a reciprocal duty to protect and support them as well as to provide necessary and sufficient protective equipment and supplies that will "maximally minimize risk" to nurses and other health-care providers (Human Resource Recommendations, SARS Human Resources Working Group, Ontario Hospital Association, as recorded in Godkin & Markwell, 2003). Nurses will also need to use their professional judgment to select and use the appropriate prevention measures; select, in collaboration with the health-care team, the appropriate agency, manufacturer and government guidelines concerning use and fit of personal protective equipment; and advocate for a change when agency, manufacturer or government guidelines do not meet the infection control requirements regarding appropriate use and fit of personal protective equipment (College of Nurses of Ontario, 2005).

Nurses need to carefully consider their professional role, their duty to provide care and other competing obligations to their own health, to family and to friends. In doing so, they should be clear about steps they might take both in advance of and during an emergency or pandemic situation so that they are prepared for making ethical decisions (Faith, Gibson, Thompson & Upshur, 2005). Value and responsibility statements in the code should support nurses' reflection and actions.

A. *In anticipation of the need for nursing care in a disaster or disease outbreak, nurses:*

- work together with nurses and others in positions of leadership to develop emergency response practice guidelines, using available resources and guidelines from governments, professional associations and regulatory bodies;
- learn about and provide input into the guidelines the region, province or country has established regarding which persons are to receive priority in care (e.g., priority based on greatest need, priority based on probability of a good outcome, and so on);
- learn how support will be provided for those providing care and carrying the physical and moral burden of care;
- request and receive regular updates about appropriate safety measures nurses might take to protect and prevent themselves from becoming victim to a disaster or disease;
- assist in developing a fair way to settle conflicts or disputes regarding work exemptions or exemptions from the prophylaxis or vaccination of staff; and
- help develop ways that appeals or complaints can be handled.

B. When in the midst of a disaster or disease outbreak, nurses have an ethical obligation to:

- refer to regulations and guidelines provided by government, regulatory bodies, employers and professional associations;
- help make the fairest decisions possible about the allocation of resources;
- help set priorities in as transparent a manner as possible;
- provide safe, compassionate, competent and ethical care (in disasters, as much as circumstances permit);
- help determine if, when and how nurses may have to decline or withdraw from care; and
- advocate for the least restrictive measures possible when a person's individual rights must be restricted.

Ethical Considerations in Relationships with Nursing Students

Registered nurses in all roles share the responsibility of supporting nursing students in providing safe, competent, compassionate and ethical care. Several statements in the code include specific references to students and their relationships with others in providing nursing care:

> *Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way. (Code, D10)*

> *Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members. (Code, G9)*

On the basis of these statements in the code, the following guidelines are suggested:

- All teacher-student interactions are to be in keeping with ethical nursing practice.
- All nurses and nursing students treat each other with respect and honesty.
- All nurses endeavour to provide nursing students with appropriate guidance for the development of nursing competence.
- The primary responsibility for the care of the person remains that of the primary nurse to whom the person has been assigned.
- Nursing students ensure that persons receiving care are informed of their student status. The person's right to refuse care or assistance provided by a student is to be treated with respect.
- Nursing students are expected to meet the standards of care for their level of learning. They advise their faculty clinical instructor and their clinical unit nurse supervisors if they do not believe they are able to meet this expectation.
- If nursing students experience difficulties with disrespectful actions from nurse(s) in practice that they are not able to overcome through conversation with the nurse(s) involved, they discuss these incidents with their faculty clinical instructor and, failing helpful outcomes from that discussion within an appropriate period, they enlist the assistance of the appropriate nursing education administrator in their nursing program.

Acting Ethically in Situations That Involve Job Action

Job action by nurses is often directed toward securing conditions of employment that enable safe and ethical care of current and future persons receiving care. However, action directed toward such improvements could

hinder persons receiving care in the short term. Nurses advocate for their involvement in workplace planning for the safety of those receiving care before and during job action. Members of the public are also entitled to information about the steps taken to ensure the safety of persons during any job action.

> *Nurses planning to take job action or practising in environments where job action occurs take steps to safeguard the health and safety of people during the course of the job action. (Code, A7)*

- Each nurse is accountable for decisions made about her or his practice at all times in all circumstances, including during a legal or an illegal strike (Nurses Association of New Brunswick [NANB], 2004).
- Individual nurses and groups of nurses safeguard persons receiving care when planning and implementing any job action.
- Individuals and groups of nurses participating in job action, or affected by job action, share the ethical commitment to the safety of persons in their care. Their particular responsibilities may lead them to express this commitment in different but equally appropriate ways.
- Persons whose safety requires ongoing or emergency nursing care are entitled to have those needs satisfied throughout any job action.
- During job action, if nurses have any concern about their ability to maintain practice and ethical standards or their ability to ensure the safety of persons in their care, they are responsible for communicating this concern in accordance with identified lines of accountability so that corrective action can be taken as quickly as possible (NANB, 2004).

REFERENCES

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements.* Washington, DC: Author.

American Nurses Association. (2006). *Position statement: Risk and responsibility in providing nursing care.* Washington, DC: Author.

Burkhardt, M. A., & Nathaniel, A. K. (2002). *Ethics & issues in contemporary nursing* (2nd ed.). Toronto: Delmar Publishers.

Canadian charter of rights and freedoms, Schedule B, *Constitution Act, 1982.*

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (1998, with 2000, 2002 and 2005 amendments). *Tri-council policy statement: Ethical conduct for research involving humans.* Ottawa: Public Works and Government Services Canada. Retrieved October 22, 2007, from http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

Canadian Nurses Association. (1994). *Joint statement on advance directives* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2001). *Quality professional practice environments for registered nurses* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2002). *Ethical research guidelines for registered nurses* (3rd ed.). Ottawa: Author.

Canadian Nurses Association. (2003). *Global health and equity* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2004a). *Registered nurses and human rights* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2004b). *Everyday ethics: Putting the code into practice.* Ottawa: Author.

Canadian Nurses Association. (2006). *Social justice… a means to an end, an end in itself.* Ottawa: Author.

Canadian Nurses Association. (2007). *Framework for the practice of registered nurses in Canada.* Ottawa: Author.

Canadian Nurses Protective Society. (2004). Consent of the incapable adult. *InfoLaw 13*(3), 1-2.

Caplan, R. L., Light, D. W., & Daniels, N. (1999). Benchmarks of fairness: A moral framework for assessing equity. *International Journal of Health Services, 29*(4), 853-869.

College and Association of Registered Nurses of Alberta. (2005a). *Professional boundaries for registered nurses: Guidelines for the nurse-client relationship.* Edmonton: Author.

College and Association of Registered Nurses of Alberta. (2005b). *Ethical decision-making for registered nurses in Alberta: Guidelines and recommendations.* Edmonton: Author.

College of Nurses of Ontario. (2005). *Infection, prevention and control.* Toronto: Author.

College of Registered Nurses of British Columbia. (2006a). *Competencies in the context of entry-level registered nurse practice in British Columbia.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2006b). *Delegating tasks to unregulated care providers.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2006c). *Practice standard: Conflict of interest.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2007). *Practice standard: Duty to provide care.* Vancouver: Author.

College of Registered Nurses of Nova Scotia. (2006a). *Emergency preparedness plan.* Halifax: Author.

College of Registered Nurses of Nova Scotia. (2006b). *Problematic substance use in the workplace: A resource guide for registered nurses.* Halifax: Author.

Dutton, J., Lilius, J., & Kanov, J. (2007). The transformative potential of compassion at work. In S. K. Piderit, R. E. Fry, & D. L. Cooperrider (Eds.), *Handbook of transformative cooperation: New designs and dynamics.* Palo Alto, CA: Stanford University Press.

Evans, R. G. (1994). Introduction. In R. G. Evans, M. L. Barer, & T. R. Marmor (Eds.), *Why are some people healthy and others are not? The determinants of health of populations* (pp. 3-26). New York: Aldine de Gruyter.

Faith, K., Gibson, J., Thompson, A., & Upshur, R. (2005). *Ethics in a pandemic influenza crisis: Framework for decision-making.* Toronto: Clinical Ethics Centre at Sunnybrook & Women's College Health Sciences Centre.

Fenton, M. (1988). Moral distress in clinical practice: Implications for the nurse administrator. *Canadian Journal of Nursing Administration, 1*, 8-11.

Fry, S., & Johnstone, M-J. (2002). *Ethics in nursing practice: A guide to ethical decision-making* (2nd ed.). International Council of Nurses. Oxford: Blackwell.

Godkin, D., & Markwell, H. (2003). *The duty to care of healthcare professionals: Ethical issues and guidelines for policy development.* Toronto: Submission to the SARS Expert Panel Secretariat.

Hebert, P. C., Hoffman, C., & Davies, J. M. (2003). *The Canadian safety dictionary.* Edmonton: Canadian Patient Safety Institute.

International Council of Nurses. (2006). *ICN code of ethics for nurses.* Geneva: Author.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice Hall.

Matthews, J. (2007). *Nursing ethics decision-making algorithm.* Available at www.cna-aiic.ca.

Morin, K., Higginson, D., & Goldrich, M. (2006). Physician obligation in disaster preparedness and response. *Cambridge Quarterly Healthcare Ethics, 15*, 417-431. [This paper was prepared for the Council on Ethical and Judicial Affairs of the American Medical Association.]

Neufeldt, V., & Guralnik, D. G. (1988). *Webster's new world dictionary* (3rd ed.). New York: Simon & Schuster.

Nurses Association of New Brunswick. (2004). *Professional accountability during a strike.* Fredericton: Author.

Oberle, K. & Raffin, S. (in press). *Nursing ethics in Canadian practice.* Toronto: Pearson.

Office of the High Commissioner for Human Rights, United Nations. (1948). *The universal declaration of human rights: A magna carta for all humanity.* Geneva: Author.

Public Health Agency of Canada. (2003). *What determines health?* Retrieved October 22, 2007, from http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html

Registered College of Nurses, Australia. (2000). *Position statement: Conscientious objection.* Canberra: Author.

Registered Nurses Association of Nova Scotia. (1996). *Violence in the workplace: A resource guide.* Halifax: Author.

Registered Nurses' Association of Ontario. (2006). *Collaborative practice among nursing teams.* Healthy work environments best practice guidelines. Toronto: Author.

Registered Nurses' Association of Ontario. (2007a). *Embracing cultural diversity in health care: Developing cultural competence.* Healthy work environments best practice guidelines. Toronto: Author.

Registered Nurses' Association of Ontario. (2007b). *Professionalism in nursing.* Healthy work environments best practice guidelines. Toronto: Author.

Rodney, P., Hartrick Doane, G., Storch, J., & Varcoe, C. (2006). Toward a safer moral climate. *Canadian Nurse, 102*(8), 24-27.

Rodney, P., & Starzomski, R. (1993). Constraints on moral agency of nurses. *Canadian Nurse, 89*(9), 23-26.

Rodney, P., & Street, A. (2004). The moral climate of nursing practice: Inquiry and action. In J. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 209-231). Toronto: Pearson-Prentice Hall.

Storch, J., Rodney, P., & Starzomski, R. (2004). *Toward a moral horizon: Nursing ethics for leadership and practice.* Toronto: Pearson-Prentice Hall.

Varcoe, C., & Rodney, P. (2002). Constrained agency: The social structure of nurses' work. In B. S. Bolaria & H. Dickenson (Eds.), *Health, illness and health care in Canada* (3rd ed., pp. 102-128). Scarborough, ON: Nelson Thomas Learning.

Webster, G., & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

World Health Organization. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978. Retrieved March 19, 2008, from http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

World Health Organization. (2006). Constitution of the World Health Organization (45th ed. Suppl.). Retrieved October 31, 2007, from http://www.who.int/governance/eb/who_constitution_en.pdf

Yeo, M., & Moorhouse, A. (1996). *Concepts and cases in nursing ethics* (2nd ed.). Peterborough, ON: Broadway Press.

ETHICS RESOURCES

In addition to the resources listed in the references, there is a wide range of ethics resources available from the websites of CNA and the provincial and territorial registered nurses' associations and colleges, as well as from the websites of other national organizations such as the Public Health Agency of Canada, Health Canada, other health profession associations, and ethics or bioethics centres across Canada and internationally.

Nurses should also consult with members of their health-care team, ethics consultants in their agency, ethics committees in their facilities or region, practice consultants at nursing associations and colleges, and others with ethics knowledge and skill in its application to health-care practice.

To visit CNA's ethics resources, go to **www.cna-aiic.ca**.

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA