Ethics in Professional Nursing Practice

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But nurses are still reaching out towards ideals which we trust may be realized in the fullness of time.

—Isabel Hampon Robb, 1900

OBJECTIVES

After reading this chapter, the reader should be able to:

1. Delineate key historical events or activities that led to the development of the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) as it is known today.
2. Formulate implications for nursing practice based on the language changes in the 2001 ANA *Code of Ethics for Nurses with Interpretive Statements*.
3. Explore the significance of concepts that are interwoven in the 2001 ANA *Code of Ethics for Nurses with Interpretive Statements* to nursing practice (see also Appendix A).
4. Compare and contrast the six professionalism and boundary concepts of nursing practice in terms of the deontology and utilitarian frameworks.
5. Investigate the eight concepts of the eHealth Code of Ethics as they relate to the fundamental principle of respect for persons.
6. Discuss the Internet Healthcare Coalition's tips for nurses to help patients and themselves in evaluating the quality of health information on the Internet.
7. Analyze potential human ethical violations that place the basic fundamental ethical principles of autonomy, beneficence, and nonmaleficence at stake.

KEY TERMS

Ethical codes	Basic dignity	Personal dignity
Giving respect	Maintaining confidentiality	Having moral courage
Culture	Giving culturally sensitive care	ASK
Power	Using power	Being a good citizen of the world
Telehealth		

Professional Codes of Ethics in Nursing

The beginning of professional nursing can be traced to 19th-century England to the school that was founded by Florence Nightingale, where profession-shaping ethical precepts and values were communicated (Kuhse & Singer, 2001). Nightingale's achievement was a landmark in nursing even though graduates of her school performed below desired expectations in the early days. For the first 30 to 40 years in Nightingale's school, the prospective nurses were trained by male physicians because there were not enough educated nurses to teach nursing. Because of the strong medical influence, early nursing educators focused on technical training rather than on the art and science of nursing, as Nightingale would have preferred.

By the end of the 19th century, modern nursing had been established, and ethics in nursing was seriously being discussed. The presence of the Nightingale Pledge, first developed in 1893 and written under the chairmanship of Detroit nursing school principal Lystra Gretter, helped establish nursing as an art and a science (as cited in Dossey, 2000). The International Council of Nurses (ICN), which has been a pioneer in developing a code of nursing ethics, was established in 1899. By 1900, the first book on nursing ethics, *Nursing Ethics: For Hospital and Private Use*, had been written by the American nursing leader Isabel Hampton Robb.

Historically, a primary value consideration in nursing ethics has been the determination of the focus of nurses' work. It is interesting to note that in Isabel Hampton Robb's nursing ethics book of 1900, the titles of the chapters were descriptive of the times, such as Chapter 4: The Probationer, Chapter 7: Uniform, Chapter 8: Night-Duty, and Chapter 12: The Care of the Patient (nurse-physician, nurse-nurse, nurse-public relationships). Refer to Box 3.1 for excerpts from Robb's book representing nursing's environment in 1900.

Until the 1960s, the focus in the nursing codes was on the physician, which is not surprising, based on the fact that over the years most nurses have been women and most doctors have been men. The focus on nurses' obedience to physicians remained

BOX 3.1: HIGHLIGHTS FROM THE FIELD

Excerpts from Nursing Ethics by Isabel Hampton Robb: The Physician-Nurse Relationship in 1900

- Unfortunately, here and there we find a nurse who through *ignorance*—but far more often from the gradual growth in her of self-conceit and an exaggerated idea of her own importance—may overstep the boundary limit . . . [*italics* added for emphasis]. (pp. 249–250)
- Moreover, if in prescribing the procedures to be employed the physician goes into minute details as to the way in which certain of them are to be carried out, *his wishes are to be law to the nurse*. The question whether she agrees perfectly with his recommendations, or believes that her own methods are better, has no bearing upon the case. Apart from the fact that she may be quite wrong in her opinions, *her sole duty is to obey orders*, and so long as she does this, *she is not to be held responsible for untoward results* [*italics* added for emphasis]. (p. 250)

Quoted from Robb, I. H. (1916). The care of the patient: Relation of the nurse to the physician. *Nursing ethics: For hospital and private use*. Cleveland, OH: E. C. Koeckert. [Original publication 1900]

at the forefront of nursing responsibilities into the 1960s, and this assumption was still reflected in the ICN *Code of Ethics for Nurses* as late as 1965. By 1973, however, the focus of the ICN code reflected a shift in nursing responsibility from the physician to the patient, where it remains to this day.

Ethical codes are systematic guidelines for shaping ethical behavior that answer the normative questions of what beliefs and values should be morally accepted. However, it must be noted that no code can provide absolute or complete rules that are free of conflict and ambiguity. Because codes are unable to provide exact directives for moral reasoning and action in all situations, some people have stated that virtue ethics provides a better approach to ethics because the emphasis is on a person's character rather than on rules, principles, and laws (Beauchamp & Childress, 2001). Proponents of virtue ethics consider that if a nurse's character is not virtuous, the nurse cannot be depended on to act in good or moral ways even with a professional code as a guide. Professional codes, however, do serve a useful purpose in providing direction to

health care professionals although, ultimately, one must remember that codes do not eliminate moral dilemmas and are of no use without professionals who are motivated to act morally. For the code to have more meaning, Benner contended when speaking of the nurse's role in working for social justice, "each of us and each nursing organization" must "breathe life into the code by taking individual and collective action" (Fowler & Benner, 2001, p. 437).

American Nurses Association Code of Ethics for Nurses

"A Suggested Code" was published in the *American Journal of Nursing (AJN)* in 1926 by the American Nurses Association (ANA) but was never adopted; in 1940 "A Tentative Code" was published in *AJN*, but again was never adopted. The ANA adopted its first official code in 1950 (Daly, 2002). Three more code revisions occurred before the creation of the interpretative statements in 1976. Although it has always been implied that the code reflects ethical provisions, the word "ethics" was not added to the title until the 1985 code was replaced with its sixth and latest revision in 2001. The ANA (2001) code contains general moral provisions and standards for nurses to follow, but specific guidelines for clinical practice, education, research, and administration are found in the accompanying interpretive statements (see Appendix A for the ANA *Code of Ethics for Nurses with Interpretive Statements*).

The code is nonnegotiable with regard to nursing practice. Significant positions and changes in the 2001 ANA code included a(n): (1) return to the word "patient" rather than client; (2) application of ethical guidelines to nurses in all roles, not just clinical roles; (3) concession that research is one but not the only method contributing to nursing professional development; (4) reaffirmation against the participation of nurses in euthanasia; (5) emphasis that nurses owe the same obligations to themselves as they do to others; and (6) recommendation that members who represent nursing associations are responsible for expressing nursing values, maintaining professional integrity, and participating in public policy development (see Appendix A).

Fowler (Fowler & Benner, 2001) and Daly (2002), nursing leaders involved in revising the 2001 code, have proposed that the new code is clearly patient focused whether the patient is considered to be "an individual, family, group, or community" (Daly, p. 98). The nurse's loyalty must be first and foremost to the patient, even though institutional politics is a force in today's nursing environment. With the expanding role of nurse administrators and advanced practice nurses, each nurse must be cognizant of conflicts of interest that could potentially have a negative effect on relationships with patients and patient care. Nursing has often overlooked the responsibility to the patient held by nurses who are not in clinical roles. It is worth noting

that nurse researchers, administrators, and educators are indirectly but still involved in supporting patient care. According to Fowler (Fowler & Benner, 2001), "it is not the possession of nursing credentials, degrees, and position that makes a nurse a nurse, rather it is this very commitment to the patient" (p. 435). Therefore, the code applies to all nurses regardless of their role.

One issue that created a vigorous debate during the 2001 revision of the code involved the ethical implications of collective bargaining in nursing (Daly, 2002). Ultimately, those nurses who formulated the revisions underscored the importance for the code to contain provisions supporting nurses who work to assure that the environment in which they work is conducive to quality patient care and that nurses are able to fulfill their moral requirements. Collective bargaining was determined to be an appropriate avenue for more than just negotiating for better salaries and benefits. Today nurses consider collective bargaining as a way to improve the moral level of the environment where nurses work.

Values and virtues are emphasized in the ANA (2001) *Code of Ethics for Nurses with Interpretive Statements*. Values in nursing encompass an appreciation of what is important for the nurse personally as well as what is important for patients. The ANA emphasized the magnitude of moral respect for all human beings, including the respect of nurses for themselves. Self-respect can be thought of as personal regard. Personal regard involves nurses extending attention and care to their own requisite needs. Nurses who do not regard themselves as worthy of care usually cannot fully care for others.

The ANA (2001) included statements in the code about wholeness of character, which pertains to knowing the values of the nursing profession and one's own authentic moral values, integrating these two belief systems, and then expressing them appropriately. Integrity is an important feature of wholeness of character. In a health care system often burdened with constraints, politics, self-serving groups, and organizations, threats to integrity can be a serious pitfall for nurses. According to the code, maintaining integrity involves acting consistently with personal values and the values of the profession. When nurses are asked or pressured to do something that conflicts with their values, such as to falsify records, deceive patients, or accept verbal abuse from others, emotional and moral suffering may occur (see moral integrity in Chapter 8). A nurse's beliefs, grounded in good moral reasoning, must guide actions even when other people challenge the nurse's beliefs. When compromise is necessary, the compromise must not be such that it compromises personal or professional values.

Recognizing the essential dignity of oneself and of each patient is another value that is basic to nursing, and it is given priority in moral reasoning. Pullman (1999) described two conceptions of dignity. One type, termed **basic dignity**, is intrinsic or

inherent and dwells within all humans, with all humans being ascribed this moral worth. The other type, called **personal dignity**, often mistakenly equated with autonomy, is an evaluative type, such as judging others and describing behaviors as dignified or undignified. Personal dignity is a socially constructed concept that fluctuates in value from community to community, as well as globally. Most often, however, personal dignity is highly valued. (Refer to the nurse-patient-family relationships section in Chapter 2 for more information on personal dignity.)

ICN Code of Ethics for Nurses

In 1953 the ICN adopted its first code of ethics for nurses. (See Appendix B for the 2006 ICN *Code of Ethics for Nurses*.) The code had been revised and reaffirmed many times. The four principal elements contained in the ICN code involve standards related to nurses and people, practice, the profession, and co-workers. These elements in the ICN code form a framework to guide nursing conduct along with practice applications for practitioners, managers, educators, researchers, and national nurses' associations.

A Common Theme in the ANA and ICN Codes

A theme common to the ANA (2001) and ICN (2006) codes is a focus on the importance of compassionate patient care aimed at alleviating suffering. This emphasis is threaded throughout the codes but begins from the focal point of patients being the central focus of nurses' work. Nurses are to support patients in self-determination and are to protect the moral environment where patients receive care. The interests of various nursing associations and health care institutions must not be placed above those of patients. Although opportunities for nurses to exhibit compassion in the health care environment are not unique, nurses must always uphold the moral agreement that they make with patients and communities when they join the nursing profession. Nursing care includes the primary responsibilities of promoting health and preventing illness, but the heart of nursing care has always involved caring for patients who are experiencing varying degrees of physical, psychological, and spiritual suffering.

Ethical Reflections

- The ANA *Code of Ethics for Nurses with Interpretive Statements* currently includes the word "patient" instead of the word "client" in referring to the recipients of nursing care. Do you agree with this change? Please explain your rationale for your answer.

- Take a minute to review the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) in Appendix A. Would you add any provisions? Would you remove any provisions? Please explain your rationale for your answers.
- After reviewing the interpretive statements in the code, discuss random examples or scenarios of how nurses can justify their actions to the following approaches or frameworks: the Beauchamp and Childress principles of autonomy, beneficence, nonmaleficence, and justice; Kant's categorical imperatives based on deontology; a utilitarian framework; a virtue ethics approach; and an ethic of care approach.

Professionalism and Boundaries

In the 30th anniversary issue in 2006 of the *Journal of Advanced Nursing*, the editors reprinted and revisited the 1996 article by Esterhuizen titled, "Is the Professional Code Still the Cornerstone of Clinical Nursing Practice?," and solicited three up-to-date responses to Esterhuizen's philosophical inquiry. Verena Tschudin, one of the three respondents and editor of *Nursing Ethics*, agreed with Esterhuizen that nursing has changed only minimally, if any, regarding the lack of opportunity for personal responsibility and autonomy in moral decision making. There is plenty of fertile ground for nurses to engage in moral decisions, but they still do not have the opportunity to participate.

Tschudin (2006) reflected how article topics nowadays in *Nursing Ethics* seldom consist of codes of ethics topics as compared to years ago, but rather today reflect relationships in nursing. Nursing has moved somewhat from ethical codes of nursing to relationships in nursing because the narrative, virtue, and feminist approaches leave room for nurses to question codes of ethics, especially in the Western world. As Tschudin suggested, nurses wonder about the benefit of codes of ethics in light of today's postmodernism ambiance that leaves nurses feeling uncertain about any type of prescriptive or directive practice such as codes of nursing. One point of Tschudin's message, as evidenced by the following quote, is that nurses who have autonomy and accountability in practice do not need a code of ethics to guide them. As mentioned in the last section of this chapter, nurses who practice with a virtue ethics approach do not need a code of ethics to guide them, and Tschudin illuminated this thought by saying:

Nurses who have been educated to the level of safe practice are able to account for their own practice, and they are more likely to do this based on conscience; the relationship with a patient; or the need to express this professionalism (as a virtue): "I am a professional nurse, therefore what I do is professional." (p. 113)

Not practicing with this degree of autonomy can only lead to further moral suffering, and although codes of ethics can serve nurses well in many cases, hospitals and other agencies are not embracing the codes to the point of relevancy in nursing practice (Tschudin, 2006). An increased integration of codes of ethics at all levels of practice is necessary for a meaningful application to practice.

Even with the focus of nursing practice shifting to evidence-based nursing practice and nursing independence, codes of ethics serve as mandates for accountability in practice. The 2001 ANA and 2006 ICN codes of ethics have multiple professional boundary issues throughout the texts. Refer to Box 3.2 for examples of the ANA (2001) boundary topics and moral obligations. All seasoned and novice nurses need to become comfortable with decision-making processes that involve ethical issues, relationships, and moral judgments. The codes provide excellent guidelines for self-development in these areas, and they serve as guides for nurses whether they are clinicians, practitioners, educators, researchers, or administrators, or serve other roles.

Embedded in nursing boundaries and moral obligations of professionalism and practice are the explicit or implied concepts of respect, confidentiality, moral courage, cultural sensitivity, power, and just being a good citizen of the world. These concepts overlap with each other and do not serve as an exhaustive list of concepts for nursing professionalism and practice. Habitually practicing nursing ethics and using codes of ethics as guides help nurses to develop moral grounding by which to function. Because nursing is concerned with the nurturing of the whole person, these concepts penetrate every aspect of care, including the uniqueness of nursing in its provision of health. The Web Ethics box at the end of the chapter contains some helpful Internet sites for nurses.

Giving Respect

Giving respect to patients, families, peers, and others is a major concept in relationships, decision-making processes, and boundary issues faced by nurses on a minute-by-minute basis. Rushton (2007) defined **giving respect** as "the act of esteeming another, an act that demands we ourselves have a sense of authenticity, integrity, and self-knowledge. It demands that we honor the wholeness, the essence, and the uniqueness of the other" (p. 149).

BOX 3.2: HIGHLIGHTS FROM THE FIELD

Professional Boundaries and Moral Obligations for Nurses as Specified by the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001)

- *Clinical Practice Boundaries*
    - Respecting patients' dignity
    - Right to self-determination
    - Delegating tasks appropriately
    - Practicing good judgment
    - Accepting accountability in practice
    - Alleviating suffering
    - Being attentive to patients' interests
    - Working within the nurse practice acts and nursing standards of practice

- *Professional Practice Boundaries*
    - Maintaining authenticity in all relationships with others such as nurse-to-nurse relationships, nurse-physician relationships, nurse-to-patient relationships, and multidisciplinary collaboration
    - Addressing and evaluating issues of impaired practice; fraternizing inappropriately with patients or others; accepting inappropriate gifts from patients and families; confidentiality and privacy violations; and unhealthy, unsafe, illegal, or unethical environments

- *Self-Care and Self-Development Boundaries and Obligations*
    - Participating in self-care activities to maintain and promote moral self-respect, professional growth and competence, wholeness of character in nurses' actions and in relationships with others, and preservation of integrity
    - Advancing knowledge and research through professionalism, practice, education, and administrative contributions
    - Collaborating with other health care professionals and the public to promote community, national, and international efforts
    - Promoting healthy practices in the community through political activism or professional organizations by addressing unsafe, unethical, or illegal health practices that have the potential to harm the community

Respect is a foundational ethical principle in critical care and the hallmark of excellence in critical care practice, as Rushton pointed out, but respect for others crosses all specialties and roles in nursing. Nurses need to distinguish giving respect to people just because they are human beings from giving respect to people for their position, title, role, and political correctness. Suggestions for demonstrating respect in clinical practice and professional relationships are delineated as (1) attending to the whole person, (2) engaging authentically with patients in decision-making processes, (3) fully appreciating patients and their choices, (4) communicating effectively, and (5) remaining free of judgments, or exhibiting neutrality in communication and actions. Violations can occur when these five areas are not honored and maintained by nurses, and nurses are vulnerable to violations of respect toward patients, families, and health care professionals on an everyday basis. Potential violations include: (1) withholding information or not telling the full truth of a situation with patients, families, and professionals; (2) acting paternalistically instead of respecting another's decision; (3) giving judgment-laden nursing care and advice; and (4) not attending to the whole person or giving fragmented care.

Maintaining Confidentiality

Maintaining confidentiality means that a nurse, by legal and ethical standards, keeps information private that patients or families have disclosed unless the information falls under a limit of confidentiality (see Chapters 7 and 9 for the limits of confidentiality). Confidentiality is at the core of nurses establishing trusting relationships with other nurses, patients, families, and others. Nurses could be tempted to violate the trust that patients or professionals have established with them because of vulnerable situations *other than* for limits of confidentiality. Potential violations that lead nurses to feeling enticed to tell something secret or private include but are not restricted to:

- When nurse A is tempted to disclose a secret to nurse B about nurse C, who is planning to resign but does not yet want others to know
- Withholding information from a patient as directed by the family or physician although the nurse thinks the information should be revealed
- Patient information that is private and should only be shared within the nursing report on the unit
- A secret the nurse was told by administration to keep private

Having Moral Courage

Finding ways to establish and enhance a culture of moral courage is one of the noblest goals of humanity.

—R. KIDDER & M. BRACY, INSTITUTE FOR GLOBAL ETHICS

Having moral courage means that a nurse overcomes fear by confronting an issue head on, especially when the issue is a conflict of the nurse's core values and beliefs. Moral courage is having the will to speak out and do the right thing even when constraints or forces to do otherwise are present. Lachman (2007) emphasized that moral courage turns principles into actions. Even though physical harm could be a potential threat, other more likely threats are "humiliation, rejection, ridicule, unemployment, and loss of social standing" (p. 131). When nurses have the moral courage to do what they believe to be the right thing in a particular situation, they make a personal sacrifice by possibly standing alone, but at the same time will feel a sense of peace in their decision. If danger is a potential risk, the nurse will need to have moral courage to commit to core values, beliefs, or a moral conscience. Nurses experience apprehension and fear because of the uncertainty in outcomes even when they have a high degree of certitude that they are doing the right thing.

Lachman (2007) created a clever acronym to help nurses remember to have moral courage in situations and to remind nurses of the code of ethics for nurses. The acronym is CODE, which means:

C **C**ourage to be moral requires:
O **O**bligations to honor (What is the right thing to do?)
D **D**anger to manage (What do I need to handle my fear?)
E **E**xpression and action (What action do I need to take to maintain my integrity?) (p. 132)

Having the moral courage to admit to wrongdoing, whether the misconduct is by the nurse, a peer, or someone else, helps to rectify a situation and prevents or arrests pain and suffering associated with the moral suffering that a nurse could experience because of the wrongdoing. A few examples of moral courage are (1) confronting or reporting a peer who is stealing and using drugs at work, (2) confronting a physician who ordered questionable treatments that are not within the standard of care, (3) confronting an administrator regarding unsafe practices or staffing patterns, and (4) standing against peers who are planning an emotionally hurtful action toward another peer.

Lachman (2007) offered two strategies to help nurses to exhibit moral courage in dangerous situations. First, nurses must try to soothe their inner feelings so that fear will not trigger careless or hasty behavior in which nurses would later regret or even passivity with no reaction at all. Self-talk, relaxation techniques, and an analytical method of processing information, while pushing out negative thoughts, are ways for nurses to keep calm in the face of a confrontation involving moral courage. Second, nurses must assess the whole scenario while identifying the risks and benefits involved in standing alone.

Giving Culturally Sensitive Care

If a person could actually see cultural diversity in America from a far off place, it would look like a tapestry of beautifully woven fabrics. America as a tapestry of diversity is labeled "the melting pot," but more recently one teen immigrant, when referring to cultural differences causing violence and confrontations, said that Americans have more of an appearance akin to "a salad bowl with lots of little chunks in it" (In the Mix, 2007). The analogy that this teen made is an excellent portrayal of Americans today.

Nurses must be ethically and culturally sensitive to caring for culturally diverse patients within the health care system in the United States. **Culture** refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups" (Lipson & Dibble, 2005, p. xi). **Giving culturally sensitive care**, based on nurses applying ethical components of a trusting, respectful, and responsible relationship with others, means that nurses possess, according to Spector (2004), "basic knowledge of and constructive attitudes toward the health traditions observed among the diverse cultural groups found in the setting in which they are practicing" (p. 8).

Without some degree of cultural knowledge, nurses cannot possibly provide ethical care; for instance, relationships with others will not develop into a trusting, respectful exchange. Lipson and Dibble's (2005) trademark name, **ASK**, serves as an acronym that nurses can use when approaching patients of various cultures; it refers to awareness, sensitivity, and knowledge. Because patients know themselves best, nurses need to implement ASK when approaching their patients. There are many views in the United States, based on each culture's belief system, regarding health, illness, pain, suffering, birth, parenting, death, dying, health care, communication, truth, and many other issues that nurses must attempt to comprehend.

Lipson and Dibble (2005) emphasized that nurses should use the term *ASK* instead of the term *competence* because they believe that competence signifies an expert, mastery level that is an unreachable goal for most nurses working in a setting with many cultures of people. Good cultural assessments are known to take multiple hours in duration, time that nurses do not have, so a basic set of questions needs to be asked of patients upon admission to a facility. Lipson and Dibble's (2005) basic cultural assessment questions were adapted from Lipson and Meleis (1985), and are:

1. What is the patient's ethnic affiliation?
2. Who are the patient's major support persons and where do they live?
3. With whom should we speak about the patient's health or illness?
4. What are the patient's primary and secondary languages, and speaking and reading abilities?
5. What is the patient's economic situation? Is income adequate to meet the patient's and family's need? (p. xiii)

Refer to Box 3.3 for communication variations that are critical to nurses providing ethical care. Verbal and nonverbal variables can limit the communication process. Some languages, such as Spanish, have numerous dialects, making the communication process difficult.

America is indeed little chunks in a big bowl of salad! To exhibit professionalism through ethically competent care, nurses must be attentive to the many variations. The *Code of Ethics for Nurses with Interpretive Statements* (2001) contains explicit guidelines for giving care to individuals regardless of social or economic status, personal attributes, or nature of health problems. Giving care based on the code includes giving care with cultural sensitivity.

Communication is integral for a correct understanding and comprehension of health care treatments, directives, and other exchanges. The U.S. Department of Health and Human Services Office of Minority Health (1997) set forth 14 standards for cultural care titled *National Standards on Culturally and Linguistically Appropriate Services* (CLAS standards). The standards are supposed to be integrated into all facets of care in organizations, institutions, and agencies (see Box 3.4 for the CLAS standards). CLAS standards are organized by themes: Standards 1 to 3: culturally competent care; Standards 4 to 7: language access services; and Standards 8 to 14: organizational supports for cultural competence.

The Office of Minority Health has suggested that the Joint Commission apply Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13 for the areas of ethics, rights, and responsibilities; provision of care, treatment, and services; leadership; managing the environment of care;

BOX 3.3: HIGHLIGHTS FROM THE FIELD

Lipson and Dibble's (2005) *Cultural Variations in Communication*

Conversational Style and Pacing
- Silence can be significant and indicate respect or acknowledgement of the speaker.
- Words such as "no" can be rude if spoken aloud.
- Conversations vary from abruptness to indirect styles or from loudness to softness.
- People of some cultures will tell whole stories to communicate a point.
  Examples:
  ◦ Italians tend to be volatile, passionate, and loud.
  ◦ American Indians can be soft spoken, clear, and direct, and view loudness as being rude.
  ◦ Russians can be direct and tend to say exactly what they think so that no one misunderstands them.

Eye Contact
- Variations in eyes include intense, direct eye contact and fleeting, roving eyes.
- People of some cultures believe that avoiding direct eye contact is necessary to convey respect, not to invade privacy, or to convey gender exchange.
  Examples:
  ◦ Vietnamese often do not make eye contact with someone of unequal status, age, or opposite gender.
  ◦ Iranians often find that direct eye contact is acceptable, especially for those of equal status.
  ◦ African Americans generally make direct eye contact, but eye contact may vary among the generations.

Personal Space
- Variations in personal space occur.
- Standing away or backing away from someone means that the person wants distance.
- Standing too close to a person can signal aggressiveness.

(continued)

BOX 3.3: HIGHLIGHTS FROM THE FIELD (CONTINUED)

Examples:
- ○ The Chinese often require a comfort zone of 4 to 5 feet, but have a preference of side to side rather than face to face communication.
- ○ The Polish tend to prefer close proximity with family members and friends but a little more distance with strangers (which includes health care professionals).
- ○ Gypsies tend to prefer extremely close proximity to others, even more so than the U.S. dominant culture.

Touch
- Touch differs in each culture from complete touching to no touching.
- People of some cultures believe that touching is taboo for certain areas of the body.
- People of some cultures believe that touching is more appropriate for those of the same gender whereas touching of unrelated people or the opposite gender is taboo.
- People of some cultures believe that receiving health care from the opposite gender, especially when care involves genital handling such as Foley catheter insertion, is taboo.

Examples:
- ○ Mexicans often like touching close friends and family members but experience discomfort when touched by strangers (which includes health care professionals).
- ○ Pakistanis, specifically Muslim Pakistanis, try to avoid touching the opposite gender from puberty and beyond if they are not married or are not blood kin.
- ○ Hawaiians often prefer permission before being touched, and then only handshakes or touching of the shoulder are acceptable.

Time Orientation
- Time orientation with some cultures is very significant, such as in the U.S. dominant culture.

BOX 3.3: HIGHLIGHTS FROM THE FIELD (CONTINUED)

- People of some cultures do not place enormous value on time orientation but would rather complete an interaction and discussion with someone they have encountered.
  Examples:
  - Jamaicans and Central Americans tend to view being on time as less important as compared to other aspects of living.
  - Filipinos are generally oriented to past and present time, but future time commitments are based on a *bahala na* (Filipino for leave it to God) approach to time commitments.
  - Germans are generally extremely punctual, even setting their clocks ahead to avoid a rush to a deadline, and they display intolerance to others' tardiness.

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and managing information. As of May 2007, the Joint Commission has incorporated these standards into accreditation requirements for hospitals. Regarding the ethics, rights, and responsibilities area, The Joint Commission (2007) stated:

[Patients/residents/clients] deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial, and spiritual values. These values often influence the [patient/resident/client]'s perceptions and needs. By understanding and respecting these values, providers can meet care, treatment, and service needs and preferences. (p. 2)

Using Power

The nurse-patient relationship has infinite untold and unrealized power.

—JANIE B. BUTTS

"Without power, there is no action" (Hakesley-Brown & Malone, 2007, Section 2, Para. 1). **Power**, by definition, means that a group or person has influence over others in an effective way. The author of this chapter has defined **using power**, as surmised from various aspects of the literature including Manojlovich (2007), as the ability of nurses to influence persons, groups, or communities by controlling the con-

BOX 3.4: HIGHLIGHTS FROM THE FIELD

The CLAS Standards

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

(continued)

Box 3.4: Highlights from the Field (continued)

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

(continued)

BOX 3.4: HIGHLIGHTS FROM THE FIELD (CONTINUED)

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Quoted from U.S. Department of Health and Human Services Office of Minority Health. (1997). National standards on culturally and linguistically appropriate services (CLAS). Retrieved April 20, 2007, from http://www.omhrc.gov/templates/browse. aspx?lvl=2&lvlID=15

tent of their practice, the context of their practice, and their competence in practice. These domains of control—content, context, and competence—have become critically important in light of magnet recognition and evidence-based practice in nursing. As Manojlovich stated, "All of the magnet hospital [reported] studies have . . . consistently demonstrated positive benefits for nursing and patients when nurses control both the content and context of their practice" (Control Over the Context of Nursing Practice Section, Para. 2). However, Manojlovich conveyed a fear that these three domains are not enough to help nurses realize their power, mainly because nurses possibly do not understand how power can develop from relationships. Nurses need to increase their understanding of sources of power in the practice arena, to expand their view of empowerment with the idea that empowerment serves as a motivating factor, and to foster and nurture relationships that contribute to nursing power.

The nurse-patient relationship is a powerful force to be reckoned with for the future. The public and health care professionals will come to see the vision of power for nurses as a reality of infinite possibilities. Quality of care dictates all facets of health

care. Hakesley-Brown and Malone (2007) explored nurses and patients as being an all powerful entity that has evolved over time because of clinical, political, and organizational power paradigm shifts. Nurses have facilitated patients' emancipation from a previous paternalistic form of care to today's autonomous decision makers seeking quality care. With nurses being directly involved in quality of care, nurses are in a prime position to use power to benefit not only patients, but also the professional practice of nursing.

In fact, the nurse-patient relationship has infinite untold and unrealized power. Perceptions are more powerful than just facts. Duffy and Duffy (1998) so characteristically emphasized this fact by words from the title of their article, "Power Perceived Is Power Achieved." These authors believe that even though changing perceptions is a difficult task, nurses have the power to be powerful through the hard work of effectively communicating the service provided to customers and others, talking the customer's language, building alliances, being competitive in a healthy environment, and listening to their customers.

The author of this chapter found one study most interesting—qualitative interviews by Ponte, Glazer, Dann, and colleagues (2007), who were developing a fast-track BSN-to-PhD nursing program and wanted to explore the concept of power in nursing. The development of this program was a large collaborative effort among several organizations. They interviewed nursing leaders from six organizations to understand, from the leaders' perspectives on the concept of power, ways that nurses can acquire power and ways that these leaders demonstrate power in their practice and work. From the beginning of the fast-track development, Ponte et al. wanted to incorporate characteristics associated with power into the program so that students in the program could learn how to attain positions of power. What they found was extremely valuable material, especially the mentoring component between PhD students and nursing leaders from academia and health care organizations.

According to these leaders, power lies within each nurse who engages in patient care, administrative leadership, teaching, and research. These interviewed nursing leaders emphasized the power of individual nurses through patient care, families, organizations, colleagues, and the nursing profession as a whole. As nurses develop knowledge and expertise in practice from multiple domains, these experts integrate and use their power in a "collaborative, interdisciplinary effort focused solely on the patients and families that the nurse and care team serve and with whom they partner" (Ponte et al., 2007, Characteristics of Nursing Power section, Para. 1). From these interviews, the authors extrapolated eight properties of a powerful professional practice, which could serve as a basis for current and future power in nursing. Refer to Box 3.5 for the properties of power.

Box 3.5: Highlights from the Field

Ponte et al.'s Properties of a Powerful Professional Nursing Practice

Nurses who have developed a powerful nursing practice...
- Acknowledge their unique role in the provision of patient- and family-centered care.
- Commit to continuous learning through education, skill development, and evidence-based practice.
- Demonstrate professional comportment [manner in which one conducts self] and recognize the critical nature of presence.
- Value collaboration and partner effectively with colleagues in nursing and other disciplines.
- Actively position themselves to influence decisions and resource allocation.
- Strive to develop an impeccable character; to be inspirational, compassionate, and have a credible, sought-after perspective (the antithesis of power as a coercive strategy).
- Recognize that the role of a nurse leader is to pave the way for nurses' voices to be heard and to help novice nurses develop into powerful professionals.
- Evaluate the power of nursing and the nursing department in organizations they enter by assessing the organization's mission and values and its commitment to enhancing the power of diverse perspectives.

Quoted from Ponte et al. (2007). The power of professional nursing practice—An essential element of patient and family centered care. *The Online Journal of Issues in Nursing, 12*(1) [Manuscript #3]. Retrieved April 20, 2007, from http://www.nursingworld.org/ojin/topic32/tpc32_3.htm

Ethical Reflections

There are a variety of ways that power can be abusive, coercive, or not used at all. Nurses who do not use their power for the good of a situation are ineffective. There are two examples of power presented here, one on a small scale and one on a large scale.

- This first scenario is an example of the nurse-patient relationship on a smaller scale. Ms. Gomez, whose diagnosis is inoperable and incurable cancer of the liver, is unaware of her

diagnosis but realizes that she is experiencing abdominal pain that she described as 8 on a 10-point scale. Ms. Gomez is located on the cancer unit of the hospital. Everyone involved in her care is aware of her diagnosis except for her. She senses something is terribly wrong and begins to panic when physicians gather in her room and begin to discuss her "case" in front of her. Ms. Gomez could have had a better patient outcome if the nurse would have persuaded the physicians to leave her room to discuss her case and/or for them to tell her the truth about her diagnosis and prognosis. Had the nurse exerted a noncoercive power over this situation, Ms. Gomez would not have panicked. *What specific actions could this nurse have taken on a small-scale or unit level in terms of unit policies regarding clinical rounds or disclosure to patients?*

• This second scenario is an example of the nurse-patient relationship on a larger scale. Nurse Mary is a hospice nurse located in a coastal region and has six patients in her care. She saw and heard on television the national weather center forecast of several life-threatening hurricanes hitting her region during the coming hurricane season. Most of her patients are financially challenged. The nurse has choices to make: (1) she could do nothing and let nature take its course; (2) she could educate her patients and families on ways to prepare for disaster; or (3) she could educate her patients and families on disaster preparedness as well as use her power by helping poor, homebound patients—not just her patients—in her community to prepare for disaster. One way to help on a large scale could be to have a fundraiser and supply drive in her community, and once the drive is over, to recruit community or nurse volunteers, through efforts of the American Red Cross or in other ways, to distribute the supplies, hand out disaster preparedness information, and verbally educate the families. *What are other ways that this nurse or other nurses could implement to influence the community to help these patients?*

Being a Good Citizen of the World

Being a good citizen of the world, as defined by Crigger, Brannigan, and Baird (2006), means that nursing professionals "think reflectively about themselves and others, understand others' point of view, and promote social justice" (p. 23). Being a good citizen of the world entails a certain degree of cultural sensitivity in practice and in relationships. However, cultural knowledge is not the only criterion; it also involves being a compassionate professional nurse, which according to Crigger et al. is currently in the process of being defined. Part of the developing definition of being a compassionate professional nurse involves embracing a high level of social justice com-

mitment in health care for all people and nations. (See more on social justice in Chapter 2.)

Professional nurses need to actively engage in seeking better health for the world at large. One particular entity that Crigger et al. (2006) related was the 10/90 rule of research, meaning that 10% of the world's population receives 90% of the research grants, leaving a wide disparity between the rich and poor countries. Politically working to equalize research funding distribution can be an essential part of being a good citizen of the world. Partnering through global collaborative and multidisciplinary research efforts to prevent and combat serious diseases and to decrease poverty is a primary target for nurse researchers. Curricula in schools of nursing at the graduate and undergraduate levels should consist of concepts of social justice and strategies for commitment to global health. Nursing's global mission is to support and work toward a common good. The vision of Sigma Theta Tau International Honor Society (2007) is "to create a global community of nurses who lead in nursing knowledge, scholarship, service and learning to improve the health of the world's people."

Ethical Reflections

After reading this section on professionalism and boundaries, you have learned about some of the concepts that help to make up a nurse's ethical professional composition, which include but are not limited to respect, confidentiality, moral courage, culturally sensitive care, power, and good global citizenship. The concepts overlap with each other. Habitually practicing nursing ethics and using codes of ethics as guides help nurses to develop moral grounding by which to function regarding professionalism.

Test your personal moral grounding! List the professional concepts from this section on a piece of paper and write down how they could relate to your professional nursing practice by briefly summarizing an example of an ethical situation or conflict that could arise with each concept and possible resolutions for each example:

- Giving respect
- Maintaining confidentiality
- Having moral courage
- Giving culturally sensitive care
- Using power
- Being a good citizen of the world

Codes of Ethics for Internet Use and Telehealth

The Internet has become an unprecedented phenomenon. Almost 1 billion people have connected to this global electronic community. Of the 6.6 billion people in the world early in 2007, there were 1.114 billion Internet users in all countries (Miniwatts Marketing Group, 2007). The makeup of these 1.114 billion users, in order, is Asia 36%, Europe 29%, North America 21%, Latin America 8%, Africa 3%, Middle East 2%, and Oceania-Australia 1%. As nurses and nursing students take advantage of the infinite possibilities of the Internet, they need to know standards of ethical conduct when accessing information on the Internet.

Another critical aspect for nurses and nursing students is the broad and virtual world of **telehealth**, which includes virtual patient teaching, nursing information, information technology, videoconferencing, and health education. Nurses must be able to evaluate the credibility of specific Web sources and the health information for use in patient teaching. They also need to teach patients how to evaluate the credibility of Web sites and health information.

Practical Strategies for Internet Ethics

Many people who use the Internet have already experienced, to some degree, the consequences of unethical computer behavior, such as being the target of someone else's devious acts. Because of the potential for unethical and criminal behaviors, it is imperative that nurses and nursing students understand and practice ethics on the Internet. Respect for one another on the Web and a serious commitment to Web ethics must occur as existing users continue to connect and new users continue to sign on in record numbers each year.

Johnson (2003) identified three reasons for learning ethical behavior on the Internet:

1. Adults who attended school before the integration of computers and networks may not understand the virtual world and learning ethical behavior will promote good practice.
2. The virtual world requires the application of new ethical considerations because many people see their actions in the virtual world as intangible, and even if the actions are unethical, they do not perceive these actions to be nearly as unethical as they could be in the real world.
3. The virtual world and advanced technology have served as a gateway for misuse, and thus many people view their use as low-risk, game-like challenges, rather than misuse.

Point 3 is one that needs a little explanation. Some people who use the Internet frequently or for long durations have the potential to view the virtual world as a fictional place where their activities sometimes appear to them as unreal games. Misuse at that point begins to seem like a play-like challenge and not at all like actual misuse. Therefore, the people who slide into misuse as a game sometimes see nothing wrong with their Internet behaviors. A continuous and consistent exposure to best ethical practices on the Internet will keep reality at the forefront.

Although many people view computer and virtual world behaviors as intangible or not really existing, the behaviors and actions really do exist and cause many problems and concerns. All people who search and use the Internet leave their footprints or traceable evidence, such as nonerasable histories of their searches and frequented addresses on the Internet. For instance, stealing copyrighted materials, then saving them to one's personal files, will reveal evidence of the original author of these materials in Properties. Police detectives can trace all transactions, cite visits, and other types of activities, such as in pedophile pornographic cases or the purcahse of illegal drugs on the Internet, even when a person has attempted to erase all files or completely recover the system. A few behaviors viewed as unethical or criminal include:

- Stealing copyrighted material and credit for intellectual property
- Intercepting private e-mail
- Displaying [pornographic] material
- Deliberately providing public misinformation
- Misusing research material
- Improper commercial/personal use of the Internet
- Stealing credit information (Security Issues on the Internet, 2005, Para. 4)

Rinaldi (1998) developed a highly regarded set of Internet guidelines, *The Net: User Guidelines and Netiquette*, that includes helpful ethical strategies for users. These strategies are everyday manners that form the foundation of respect on the Internet. Nine of the 21 strategic behaviors that Rinaldi delineated for electronic communications, such as e-mails, are:

- Capitalize only the words you would normally capitalize because capitalizing whole words or sentences gives the appearance of shouting.
- Keep e-mails as short and concise as possible.
- Limit line length to 65 to 70 characters if possible.
- Place asterisks around words that need to be emphasized.
- Habitually use signatures at the end of the message.
- Avoid sending chain letters.

- Maintain professionalism when e-mailing others.
- Cite all quotes and be respectful of all copyrighted or licensed information.
- Because the emotional aspect of e-mail content is difficult to detect, use emoticons to express feelings, such as **:)** *or* **:-)** to express humor and **:(** *or* **:-(** to express sadness, and try to be very careful about how and when you express sarcasm, if ever at all.

Johnson (2003) developed the Three Ps of Technology Ethics, which are respecting people's Privacy, protecting and respecting people's Property and using technology aPpropriately and constructively and not breaking the rules of the government, school, religion, or family. Another code of conduct for usage is the ever-popular Ten Commandments by the Computer Ethics Institute (1992).

1. Thou shalt not use a computer to harm other people.
2. Thou shalt not interfere with other people's computer work.
3. Thou shalt not snoop around in other people's computer files.
4. Thou shalt not use a computer to steal.
5. Thou shalt not use a computer to bear false witness.
6. Thou shalt not copy or use proprietary software for which you have not paid.
7. Thou shalt not use other people's computer resources without authorization or proper compensation.
8. Thou shalt not appropriate other people's intellectual output.
9. Thou shalt think about the social consequences of the program you are writing or the system you are designing.
10. Thou shalt always use a computer in ways that insure consideration and respect for your fellow humans.

Dozens of ethical codes of conduct exist for users of the Internet. However, no matter how many codes exist or what population they serve, the codes are of no use if they are not practiced. Nurses and nursing students need to remember the foremost principal of "respect one another" when accessing the Internet. Refer to Box 3.6 for a discussion of a nursing student's buying an APA paper on the Internet.

Nurses and Telehealth

There is an overabundance of information on the Internet regarding best health practices and treatment options, but when nurses use the information as a resource for patient teaching, they need to have a certain degree of confidence and trust that the information is credible. Nurses also need to teach their patients how to evaluate Web sites and their content as to soundness and validity.

The power of electronic information has changed the way people are obtaining health information, products, and services. The popularity of electronic health information is astounding. As of 2006, 80% of American Internet users had searched for at least 1 of 17 major health topics on the Internet, making surfing for health information

Box 3.6: Highlights from the Field

Should I Buy This APA Paper?

Megan's Paper Assignment

Megan, a nursing student, found a Web site with advertisements from a company that for a fee would customize a nursing school APA paper on any topic of choice. She needed an APA paper on the concept of compassion in nursing practice and realized that she was overloaded with assignments from school. She contemplated whether she should buy the paper and asked herself "Should I buy this APA paper?" Without further thought, however, she completed the form and ordered the paper. The company sent the paper to her within 3 days and Megan, in turn, submitted the paper electronically to the professor as her own work.

1. Who do you think is the rightful owner of the paper?
2. Do you think the action is unethical, illegal, or both? Please explain your rationale.
3. Is this action cheating, plagiarism, or both, by common university or college standards on academic honesty? Please explain your rationale.
4. What are some values and ethical implications that Megan needed to consider before buying the paper?
5. Integrate Kant's deontology framework to develop what would have been an alternative action for Megan.
6. What is a creative strategy that Megan's teacher could have used for this assignment to reduce the chance of Megan and possibly others buying an APA paper on the Net?
7. What are some examples of other similar Web incidents considered illegal or unethical?

BOX 3.6: HIGHLIGHTS FROM THE FIELD (CONTINUED)

The story continues...

The professor required that electronic versions of the paper be submitted. What Megan did not realize was that the professor opened each document to review what name appeared in the Properties of the document. When the professor opened Megan's paper, the property name on the document was "National Nursing Papers." Much to Megan's shock and dismay, the professor questioned her regarding the name in the Properties of the document. Megan did not realize that a property name even existed or that the property name does not change on the document when saving the file to her computer. She could not give an adequate explanation for the existing name. After thinking of various options, she finally admitted to buying the paper and therefore failed the course. Megan did not receive a note dismissing her from the program for this one infraction, but the dean and professor gave her a one-time warning that if she cheated or plagiarized in any form in the future, as instructed in the university's handbook, she would be dismissed from the school of nursing and the university. Megan signed the warning document. She had no other choice if she wanted to remain in the nursing program.

8. Do you believe, based on your analysis of the deontology framework, that Megan deserved another opportunity to remain in the nursing program? Please explain your rationale.

one of the most popular pursuits for Internet users (Pew Internet and American Life Project, 2006). Other interesting findings from the report included:

- People want to be educated electronically so they search for new information or they review information for several reasons: to prepare for physician appointments or surgery, to share information with others, and to seek support.
- Women under age 65, college graduates, and home broadband users are the primary seekers of Web health information.
- Web users find support in Web groups and e-mail.
- People who seek health information and services on the Web find that their relationships with their health care providers change.

According to Crigger (2002):

Trust is a fundamental concern in ehealth. Indeed, it is fundamental to health care. To receive the care they need, patients must share private information and be willing to take medications, use medical devices, or often accept interventions that intrude on their bodies. They rely on health care providers to keep their personal information confidential, to provide accurate and appropriate information about their conditions and possible treatments, and to recommend the therapy they believe to be in the patient's interest. (Para. 2)

Health information encompasses a vast range of information on staying healthy, preventing disease, managing disease, and making health care decisions regarding products and services. Health products may include everything from medications to vitamins and nutritional supplements to medical devices. Internet users can access health care plans, health care providers, insurers, and health care facilities.

The Internet Healthcare Coalition members published their eHealth Code of Ethics with the goal of creating "a trustworthy environment for all users, whether they are patients, health care professionals, website sponsors, people who develop health applications and content on the web, or individuals who turn to the Internet to help them stay well" (as cited in Crigger, 2002, Para. 5). Many people cannot evaluate Web sites and information adequately. Therefore, coalition members issued this code of conduct for marketers, health professionals, and creators of Web sites in an attempt to enhance a trustworthy environment for consumers of health information, products, and services. Fundamental values of the eHealth Code of Ethics (as cited in Crigger, 2002) include the following eight concepts based on the ethical principle of *respect for persons*:

- *Candor:* Disclose beneficial information on the Web site.
- *Honesty:* Be truthful.
- *Quality:* Provide accurate and clear health information and provide information that will help consumers judge the credibility of your information, products, and services.
- *Informed consent:* Respect consumers' rights and how personal data may be collected, used, or shared.
- *Privacy:* Respect and protect the privacy of others.
- *Professionalism in online health care:* Respect ethical obligations to patients and consumers and educate patients and consumers about the potential limitations of electronic health information.
- *Responsible partnering:* Evaluate organizations and sites for their trustworthiness.

■ *Accountability:* Provide ways for consumers to give feedback and evaluate the site, and inquire through specific evaluative questions the extent to which the creators of the site complied with the eHealth Code of Ethics.

Numerous medical universities have Web sites with dependable and sound health information for health care professionals and the general public. Nurses need to follow the eHealth Code of Ethics as well as teach these same guidelines to patients. Every person shares in a responsibility to help assure the integrity and soundness of Internet health information. People can accomplish the task by evaluating information on the sites and providing meaningful feedback to the site creators and marketers. In hospitals and other health care institutions, nurses should post basic guidelines on bulletin boards by the computers regarding how to evaluate health information on the Internet. Refer to Box 3.7 for the Internet Healthcare Coalition's (2002) tips for nurses to help patients and themselves in evaluating the quality of health information on the Internet.

Nurses must adhere to the conduct set forth in the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) in every aspect of their nursing practice including Internet usage and the uploading and downloading of telehealth information. Patients and the general public depend highly on nurses as being trustworthy sources of reference and information. Therefore, nurses cannot risk placing themselves in jeopardy of violating that trust because of Internet and telehealth unethical practices, even if they do not realize when the information could be inappropriate or incorrect information. Given this predicament, nurses need to become savvy about evaluating Web sites for accuracy, readability, and validity before sharing the information with patients. Nurses must be Internet savvy and maintain the highest of ethical standards when evaluating health-related Web sites, else they could be placed at risk for violations in privacy, confidentiality, and trust. Based on this information, there are three ethical principles at stake:

■ *Respect for other persons—autonomy:* Trust, privacy, confidentiality, and human dignity
■ *Doing good—beneficence:* Promoting health and well-being of people by way of patient information and prevention of disease and illness
■ *Do no harm—nonmaleficence:* To patients, families, groups, and communities

Nurses need to justify or evaluate ethical behaviors on their Internet use just as they would any type of clinical practice. Frequently reflecting on and evaluating their own practice, whether on the Internet or at the bedside, for the degree to which their behaviors are morally consistent is an essential activity. By using the Gibbs Reflective Cycle delineated in Chapter 2, nurses must justify their practice behaviors and answer the following questions:

BOX 3.7: HIGHLIGHTS FROM THE FIELD

Tips for Patients and Nurses: Evaluating Quality Health Information on the Internet

- Choosing an online health information resource is like choosing your doctor. . . . A good rule of thumb is to find a Web site that has a person, institution, or organization in which you already have confidence.
- Trust what you see or read on the Internet only if you can validate the source of the information. Authors and contributors should always be identified, along with their affiliations and financial interests, if any, in the content.
- Question Web sites that credit themselves as the sole source of information on a topic as well as sites that disrespect other sources of knowledge.
- Don't be fooled by a comprehensive list of links. Any Web site can link to another and this in no way implies endorsement from either site.
- Find out if the site is professionally managed and reviewed by an editorial board of experts to ensure that the material is both credible and reliable.
- Medical knowledge is continually evolving. Make sure that all clinical content includes the date of publication or modification.
- Any and all sponsorship, advertising, underwriting, commercial funding arrangements, or potential conflicts should be clearly stated and separated from the editorial content. A good question to ask is: [Does the author or do the authors] have anything to gain from proposing one particular point of view over another?
- Avoid any online physician who proposes to diagnose or treat you without a proper physical examination and consultation regarding your medical history.
- Read the Web site's privacy statement and make certain that any personal medical or other information you supply will be kept absolutely confidential.
- Most important, use your common sense! Shop around, always get more than one opinion, be suspicious of miracle cures, and always read the fine print.

Quoted parts from Internet Healthcare Coalition. Tips for healthy surfing online: Finding quality information on the Internet. Retrieved April 20, 2007, from http://www.ihealthcoalition.org/content/tips.html

- What happened?
- What were your feelings?
- What was good and bad about the experience?
- What can you learn from the event?
- What could you have done differently or in addition?
- If it happens again what would you do?

Nurses need to apply one of the ethical frameworks at the beginning of the evaluation phase of the cycle and then move through the cycle with the ethical framework. The major frameworks include the utilitarian-consequential theory, the deontological theory, a virtue ethics approach, or an ethic of care approach. (See Chapter 1 for ethical theories and approaches.) The following Web Ethics box contains some helpful Internet sites for nurses, patients, and families.

Web Ethics

Web Sites for Nurses

American Nurses Association: Center for Ethics and Human Rights
  http://www.nursingworld.org/ethics/
  Brochure: http://www.hhs.state.ne.us/omh/docs/CLASBrochure.pdf
  Web site: http://www.omhrc.gov

Center for Social Justice
  http://centerforsocialjustice.org

International Council of Nurses—Nursing Networks, Geneva, Switzerland
  http://www.icn.ch/networks.htm

Medical Library Association, MLANET: A User's Guide to Finding and Evaluating Health
  http://www.mlanet.org/resources/userguide.html

Nursing Power.Net
  http://www.nursingpower.net/sitemap.html

University of Delaware Library: Internet Resources for Nursing
  http://www2.lib.udel.edu/subj/nurs/internet.htm

U.S. Department of Health and Human Service: HIPAA, Privacy, and Confidentiality
  http://www.hhs.gov/ocr/hipaa/

USDHHS, Office of Minority Health
  http://www.omhrc.gov

WalkupsWay.com—Owned and Managed by Louise Walkup, Ethics Teacher
  http://walkupsway.com

WordPress.Com: Nursing Power
  http://wordpress.com/tag/nursing-power/

Summary

This author has focused on what professionalism means to nurses and their practice or role. The author addressed three topics:

- In the first major section, professional codes of ethics in nursing, the author presented a history of the development of the ICN and ANA codes of ethics for nurses. Several significant events led to an ongoing refinement of the nursing codes. One particular activity was Nightingale's continued emphasis, both verbally and in writing, on ethical precepts and values. By the end of the 19th century, modern nursing was born, and in 1893 Lystra Gretter chaired a committee to create the Nightingale Pledge. In 1900, America's Isabel Hampton Robb wrote the first nursing ethics book, titled *Nursing Ethics: For Hospital and Private Use*. The first ANA code was adopted in 1950 and since then has evolved to the latest edition of 2001. In 1953, the ICN published its first code of ethics for nurses. ICN's code has undergone many revisions, the latest being in 2006. A common theme between the ANA and ICN codes is the significance of giving compassionate care aimed at alleviating the suffering of patients.
- The second major section, professionalism and boundaries, consisted of content on professional boundaries and moral obligations for nurses as specified by the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001). The author presented three major areas of the code: (1) clinical practice boundaries, (2) professional practice boundaries, and (3) self-care and self-development boundaries and obligations. The author extrapolated six particular concepts, explicit or implied, that are embedded in the nursing boundaries and moral obligations: (1) giving respect, (2) maintaining confidentiality, (3) having moral courage, (4) giving culturally sensitive care, (5) using power, and (6) being a good citizen of the world. Throughout these sections are ethical reflections and examples of boundary violations. The CLAS standards are also included in this section.
- The third major section, codes of ethics for Internet use and telehealth, consisted of a section on practical strategies for Internet users and a section on nurses and telehealth. Practical strategies for Internet users include a list of unethical or criminal Internet behaviors, 9 of 21 best practices for netiquette by Rinaldi, and the Ten Commandments by the Computer Ethics Institute. Included in nurses and telehealth are highlights from the Pew Internet and American Life Project research of 2006, the eHealth Code of Ethics by the Internet Healthcare Coalition, and tips for patients and nurses for evaluating the quality of health information by the Internet

Healthcare Coalition. The principle of respect serves as the basis of the eHealth Code of Ethics. When misuse occurs and when inappropriate or incorrect health information is found, three major ethical principles are at stake: (1) respect for other persons—autonomy, (2) doing good—beneficence, and (3) doing no harm—non-maleficence. Nurses must learn to be good evaluators of health information on the Internet for the sake of their patients, families, the community, and themselves.

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CHAPTER 3 QUESTIONS

1. A key event that led to the development of the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) as nurses know it today was
   a. the first formal training school of nursing created by Florence Nightingale in 19th-century England.
   b. the Nightingale Pledge of 1893 written under the chairmanship of Lystra Gretter at the Detroit school of nursing.
   c. the nursing paradigm shift in the 1970s from obedience to physicians to nurses' responsibility toward the care of their patients.
   d. Isabel Hampton Robb's focus on nurses' work in her book of 1900, *Nursing Ethics: For Hospital and Private Use*, which was the first published nursing ethics book.

2. Which one of the following responses best describes the essence of the ANA *Code of Ethics for Nurses* today?
   a. The patient-centered code serves as a guideline for nurses' ethical actions in all areas of clinical practice as well as in other nursing roles.
   b. The patient-centered code serves as a clinical guideline for nursing actions in all areas of practice as well as in other nursing roles.
   c. The code's focus is on the patient rather than the client for nursing actions in all areas of clinical practice as well as in other nursing roles.
   d. The code serves as a guideline for nurses' ethical and legal actions in all areas of clinical practice as well as in other nursing roles.

3. A best practice when caring for a patient and family who do not share your own cultural heritage is first to
   a. consult the agency's language translator.
   b. ask the patient and family to complete a questionnaire that contains a comprehensive set of questions regarding their cultural beliefs and values.
   c. conduct a basic 5-question cultural assessment by approaching the patient and family with a keen awareness, complete cultural sensitivity, and knowledge.
   d. try to understand the patient's culture by conducting trial-and-error tests such as acceptance level of touch, eye contact, and personal space.

4. An instance of exemplary moral courage that you could demonstrate in clinical practice is to
   a. break a promise that you made to another nurse about a secret that could negatively affect the daily staffing pattern on your unit.
   b. take a verbal stand against a physician in front of the patient's family by refusing to administer an ordered medication.
   c. lead a unit-wide plan of action against the nurse manger because of a disciplinary action that was enforced against a well-liked nurse co-worker who was caught leaving work and returning without punching in or out on the time clock.
   d. confront a peer who you observed placing a vial of Demerol in a jacket pocket.

5. There are three ethical principles that nurses could violate insofar as sharing tele-health information with patients. Nurse Judy was later concerned that she had violated the nonmaleficence principle when
   a. Judy called the Web Nurse Shandra and shared her patient Pam's full name, contact information, and diagnosis with Shandra for a future company marketing and sales contact.
   b. Judy retrieved information about her patient Pam's prognosis from a reputable Web site and shared this information with Pam but later found that she had retrieved inaccurate information on the prognosis.
   c. after the patient Pam requested some Web site information about the disease process, Judy did nothing to provide that information to Pam.
   d. after the patient Pam requested some Web site information about her disease process, Judy decided that the "best action" for Pam was to ask Pam's physician to come and speak with her about her disease.

CHAPTER 3 ANSWER KEY TO QUESTIONS

1. c
2. a
3. c
4. d
5. b