Guidelines

CARNA College & Association of Registered Nurses of Alberta

Ethical Decision-Making for Registered Nurses in Alberta

Guidelines and Recommendations

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Approved by the College and Association of Registered Nurses of Alberta (CARNA) Provincial Council, May 2010.

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Introduction

The purpose of the document *Ethical Decision-Making for Registered Nurses in Alberta: Guidelines and Recommendations* is to provide registered nurses in Alberta with information, resources and approaches to assist them determine and achieve ethical nursing practice within their own practice settings. The information presented on ethical decision-making in this document is not intended to dictate one way of ethical thinking for all registered nurses. Instead, the material presented is intended to enlarge our common understanding as registered nurses of:

- what ethical nursing practice is and is not, and why
- a variety of approaches which may be used by registered nurses to identify and respond to ethical questions which arise in their practice
- the resources and expertise available to registered nurses with ethical questions through their regulatory college and professional association and other professional networks

This document is not prescriptive. It does not suggest that if X situation occurs, then Y response should follow. Ethical decision-making is not that easy, nor should it ever be. We need to proceed with thought and open minds when it is human lives and suffering, harms and benefits, right and wrong that are at stake. The decisions that we make touch not only our ***clients***'[1] lives but those of the people we work with each day.

> …Ethics is not a black-and-white subject, which you either know or don't know…Ethics always involves thinking and feeling, study and practice, knowledge and intuition. As such, ethics involves the whole person of you the nurse, and the whole person of the patient or client. This is a tall order; it is also a personal challenge. (Tschudin & Farr, 1994)

This document and the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (2008a) can assist registered nurses to practice ethically and work through ethical concerns that they may face in their day to day practice.

[1] Words or phrases in bold italics are listed in the Glossary. They are displayed in bold italics upon first reference.

Ethical ***models*** and frameworks can help registered nurses consider all aspects of an ethical concern and guide them in their thinking about a particular ethical issue or concern. For many people, some styles of decision-making are more comfortable than others. Some nurses feel at home with a problem-solving method similar to the nursing process, with assessment, planning, intervention and evaluation components. This is a good approach. Other nurses feel more confident of their ethical decision-making when they apply ethical ***principles*** to arrive at their determination of ethical issues. This, too, is a sound approach. Still other nurses find that exploring relationships allows them to become aware of relevant ***values*** and perspectives to reach a decision. This is an equally valid approach. The ethical model by Oberle & Raffin is provided in the CNA *Code of Ethics for Registered Nurses*.

In this document three approaches to ethical decision making are provided. One approach is an ethical questioning model in the image of a flower and is used to highlight a series of questions to be considered when examining an ethical concern. There is no one best way to address ethical issues or to make ethical decisions. Each person must find his or her own approach, accept the struggle of developing a value system to guide their decisions, and take responsibility for their actions.

Most importantly, nurses must ask the *questions of ethics* and strive for the best resolutions possible in each unique set of circumstances. With each ethical question and action, we are changed. It is always possible to act differently, and perhaps better, next time - but only if we are willing to reflect on and critique our decisions and search for understanding of one another.

Ethical decision-making is an exercise in ethical reflection, because in the process of questioning one seeks to understand values and varying perspectives on issues. As registered nurses we strive to understand the meaning that these experiences hold for each person. Through questioning and understanding, it is expected that ethical actions become clearer, and possibilities for actions become reality.

The unique aspects of each approach to ethical decision-making demonstrate the College and Association of Registered Nurses of Alberta's (CARNA) ***belief*** that registered nurses are accountable and responsible for their own nursing practice and must be prepared to use their personal power and professional judgment to take ethical action. CARNA also believes that ethical action by nurses must be supported by other key stakeholders in the health-care system if the goal of safe, competent, ethical nursing care is to be ensured for all Albertans. The nature of ethics in modern health care requires no less.

Registered Nurses and Ethical Decision-Making

Regardless of the means chosen to approach ethical questions, several tenets hold true for all registered nurses:

1. 1. As members of a self-governing health profession, we have accountabilities to both ourselves and to the public to advocate for safe, competent, ethical nursing care.
2. 2. As people with capacity for ethical decision-making and action, it is incumbent on each of us to use all the resources at our disposal to individually and collectively advocate for a health-care system that ensures accessibility, universality and comprehensiveness of necessary health-care services.
3. 3. As parents, children, family members, neighbors and fellow citizens, we **can** in concert with all Albertans, achieve greater equity for all and a more ethical world in health care.

Recommendations for Ethical Decision-Making

Registered nurses can and should encourage ethical outcomes in health care by:

- maintaining commitment to client choice
- raising awareness of ethical issues in client care and research
- obtaining necessary consultation on ethical concerns
- becoming involved in the development of policy on ethical issues
- advocating for safe and competent nursing care within Alberta communities
- encouraging and facilitating cooperation and collaboration between professionals and between agencies to effect improvements within health care
- participating in the development of practice standards, issues statements and position papers on professional issues
- working with colleagues to identify crucial ethical issues for the profession, including:
  - the implementation of evidence-based practice
  - shaping the direction of health-care reform

- linking of resource allocation decisions to client outcomes
- providing constructive influence in ethical decision-making that arises at all levels:
  - system-wide
  - within institutions and provider groups
  - within individual nursing practice

This document contains three main parts. First, there is a broad overview of various approaches to ethical decision-making. Analyses of three very different human situations in health care are then presented, along with a non-exhaustive set of models for ethical thinking, action and review. Finally, recommendations for ethical decision-making within nursing practice are discussed. Each part of the document offers insights into ethical decision-making from a different perspective. Together, all of the parts are intended to provide a meaningful foundation for ethical nursing practice.

The Nature of Ethics

Ethics is concerned with the norms of right and wrong, of what is thought good or bad, of *ought* and *ought not*, in respect to values and behaviours between persons. Values are at the heart of ethics; they govern how we treat each other and the systems we create to bring about the care of one another.

Ethical decision-making involves ethical reasoning and behaviour about best action, based on the conviction that some actions are better than others. Moral and ethical thinking explores relations between people about how to live well as a human community. For health care, and nursing specifically, the questions of ethics and health-care ethics, of how one should act and what one should do, arise from everyday practice. Ethical reflection is part of conscious living; it is the familiar experience of finding oneself driven to wonder what should be done or what should have been done in difficult moments. Ethical issues pervade all health care and nursing practice, from the manner in which we greet each other to the decision of removing a client's feeding tube, or from the way research is conducted to the way we relate to other health professionals in providing care.

Kinds of Ethical Concerns

For registered nurses and other health-care professionals, ethical issues may be experienced as ***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 dilemmas*** (arising from the tension between two or more actions of equal moral worth) and ***ethical distress*** (feelings of guilt, concern or distaste arising out of actions or inactions imposed on a person). These experiences of ethical concern originate in the relationships and decision-making that occur around patient/client health-care situations (Canadian Nurses Association [CNA], 2008).

The nature of ethical thinking is to consider appropriate action by asking questions. These are questions like:

- What are the obvious or hidden values that influence action?
- Whose and what values are given priority?
- What are the diverse opinions influenced by societal norms, by religious perspectives or by different cultural perspectives?
- What principles guide actions?
- How do we care for one another?

As we question, we enter the arena of human relationships.

Relationships

Relationships are at the centre of ethical discussion and debate. In health care, ethics has to do with relationships between health-care providers and clients, between health-care disciplines, between agency and workers and between governments and communities. Relationships are at the center of questions like: What are the values, beliefs and wishes of the client? What are the values, beliefs and wishes of the health-care professional? The term ***relational ethics*** is often used to describe this focus.

Many nurses believe that ethical action springs from relationships. A key question concerns the types of relationships that allow for ethical nursing care to flourish. There are several different types of relationships in health care, based upon patterns of authority and responsibility. These relationships represent a continuum in the types of relationships possible, according to varying degrees of authority and responsibility. They have been categorized and described as various models of relationship: the ***expert model***, the ***contractual model***, the ***covenant model***, the ***fiduciary model***, the ***partnership model*** or the ***friendship model***.

A relational ethic accepts that both clients and professionals are individuals with beliefs and values that may differ. This ethic also accepts that individuals act on their own behalf. It involves partners who are sensitive to the particulars of the situation with respect and attention to notions of choice, tact and emotion. A relational ethic is a process, not an outcome. What this means is that at the end of the process of ethical thinking, we may or may not take a particular action. Whether or not we take action, just by being part of the process of ethical questioning, we are changed.

Context

It is important that registered nurses recognize and understand that their ethical decision- making is not done in isolation and occurs within a context of care that includes levels of relationships - societal, organizational, familial and individual. Every participant may bring a unique perspective to the decision that needs to be made. Ethical decisions affect everyone involved.

Our **societal context** of health care and ethics continues to be dominated by science and technology, with a preference for factual and testable data and lesser attention to people and human relationships. This preference affects the way we evaluate or assess human needs, encouraging us to approach ethical decision-making as mainly a problem-solving exercise not dissimilar to a *scientific approach*. This approach may often minimize the context of the web of important relationships unique to each situation.

Society, Equity and Economics

Since the early 1990s, efficiency and cost-cutting have been predominant features world-wide, and they are factors that have significantly affected Canadian health care and health services in Alberta. Placing a high value on efficiency and cost-cutting measures has led to both opportunities and disappointments. Different perspectives on health care may create challenges to Canadian values of equity as enshrined in the Canada Health Act. CARNA believes that the primary health-care model is best suited to the development of a health system in Alberta that is sustainable and meets the needs of Albertans now and in the future (CARNA, 2008a).

Organizational Context

In the practice setting there are numerous challenges and opportunities that impact on the context of care. The nursing shortage, inappropriate staffing practices and the underskilling of health-care service by assigning care to personnel with less or no formal education, and in many instances no professional regulations or standards, can put the public at significant risk for inadequate or even unsafe nursing care (CARNA, 2008b; CNA, 2009). The tension between health-care providers caused by uncertainty, lowered morale caused by apparent devaluing of nursing expertise, and increasing onerous workloads in many health-care agencies in Alberta today are concerns for many registered nurses. Families and individuals in Alberta also experience these changes, often in the face of unemployment or reduced incomes, increasing costs and/or privatization of many services and rising expectations that families can and will provide health care. All of these factors reflect a political shift in values and beliefs which many would argue is necessitated by economic crisis. However, it is critical to realize that such shifts may produce changes in personal values and beliefs.

Values and Beliefs

A **value** is defined as that which is desirable or esteemed for its own sake; something we prize, cherish or hold dear. When values are placed in the context of moral values, these values generate rights and duties. A **belief** is the conviction that something is true. Within the partnership model, there is recognition that values and beliefs are both shared and individual. Partners in a relationship each have the ability and responsibility to act within a personal value system. While there are legal and ethical values held communally, individuals (both clients and professional) have beliefs that must be respected and held to account in partnership relationships.

In nursing, value statements express broad ideals of nursing and establish responsibilities for nursing practice. As stated in the CNA *Code of Ethics for Registered Nurses* (2008a):

> The values articulated in this code are grounded in the professional nursing relationship with individuals and indicate what nurses care about in that relationship. For example, to identify health and well-being as a value is to say that nurses care for and about the health and well-being of the people they serve.

As with context, several layers of values inform the ethical questions and actions which nurses consider in their practice.

Ethics, Law and Shared Values

Some ethical values have gradually evolved into legal values. For example, **shared legal values** are found in all areas of the law, including common law and legislation. Key federal legislation includes the Canadian Bill of Rights and the Canadian Charter of Rights and Freedoms. The Charter protects certain values as **rights** for all for citizens, including the right to life, liberty and security of the person, the right to be secure against unreasonable search and seizure and arbitrary detention, and certain rights when charged with an offence.

Shared ethical values are less well defined in a single source. As noted earlier, the Canada Health Act identifies shared values foundational to the organization of health care in Canada. A central Canadian value is the recognition of the mutual **interdependency** of all people, the sense of sharing common human burdens and benefits. The CNA Code of Ethics for Registered Nurses provides statements of shared values for nurses, including **respect**: for needs and values of clients, for client choice, for confidentiality and for the dignity of clients. Also included in the code are values about nursing **responsibilities**, such as responsibility to provide competent care to clients, to maintain trust in nurses and nursing, to cooperate in health care, to protect clients from incompetence, to work for suitable conditions of employment, to take job action only with due attention to client care, to advocate for the interests of clients, to represent the values and ethics of nursing, and to ensure professional nursing associations remain responsive to the interests of clients and nurses (CNA, 2008a).

For nurses in Alberta, shared values also include the statements, positions, guidelines and practice standards developed and endorsed by Provincial Council, the governing body of CARNA, as well as CARNA-endorsed documents developed by other groups and organizations. CARNA has implemented a process of consultation with members in the development of CARNA position statements. This process provides the opportunity for nurses and their colleagues in nursing and in the health-care system to provide feedback and comments, and to identify crucial shared values for the profession.

Ethical Principles

Another way to express values is through the development of principles derived from ethical theory. Interpretations of principles vary, and our understanding of their application to practice continues to evolve. Principles do not provide a template for action. Principles assist in ethical decision-making regarding ethical action in a particular

situation. Principles central to ethical decision-making include the principles of ***autonomy***, ***beneficence***, ***non-maleficence*** and fairness or ***distributive justice***.

Autonomy

The principle of **autonomy** is the right to choose for oneself what one believes to be in one's best interests. It is the concept of self-determination, of being in charge of one's person. From this principle of autonomy comes our commitment to respect clients' choices in treatment and their need to make informed choices about matters of life and death. The rights to refuse treatment, to privacy, to truth-telling and to confidentiality are also duties which evolve from this principle.

The duties which stem out of respect for autonomy include both duties to do something to ensure client self-determination is respected and to refrain from practices that would interfere with the exercise of client decision-making. Autonomy is focused on caring relationships, with attention to cultural or other differences which might alter a client's perception of the limits of autonomy. Providing the client with accurate and honest information is critical to the exercise of client choice. Knowing how to tell the truth and how to respect a person's right to refuse "the truth" are matters requiring sensitivity and full attention to the context of the relationship.

Beneficence

The principle of **beneficence** is the ***duty*** to benefit others. A central belief reflected in this principle is the duty or obligation to assist others, to contribute to their welfare, and in doing so, to always act in the best interests of the client.

The obligation to do good towards others and to act in their best interests, without an appropriate balance of attention to the principle of autonomy, can lead to ***paternalism*** in health care. Paternalism can be a well-intended action because it aims for the client's good **but** its actual achievement in bringing about the best consequences can be in doubt as it does not balance with the patient's right to choose and be in charge of their own decisions. The doubt stems from the fact that in the paternalistic approach, it is the health professional's rather than the client's perception of the client's good that is decisive. Nurses and other health-care professionals need to ensure that decisions about a person's competence are individualized, thorough, accurate and in accordance with relevant law. Registered nurses must continue to provide opportunities for clients to make informed treatment and care decisions even if a client is sick or hurt, as they may be able to make certain kinds of decisions but not others (CNA, 2008a).

Non-Maleficence

The principle of **non-maleficence** is the duty to do no harm and to protect others from harm. Non-maleficence includes minimizing harms that may be necessary in the course of treatment, anticipating harms which might occur and avoiding harm. Such harms are not restricted to physical harms, but include feelings of helplessness, isolation and powerlessness, to name just a few of many important considerations for all health-care professionals.

The principle *to do no harm* includes attention to: a) meaningful communication between persons, b) professional standards of care, c) maintaining professional competence and d) accurate, evidence-based assessments of risks and benefits. Determining what is harm and knowing how harm is experienced by an individual client are challenges to fulfilling the obligation flowing from this principle.

Distributive Justice

The principle of **distributive justice** has as its underlying value that there be fairness based on the equal worth of individuals. While there are several criteria that may be applied to determine fairness, e.g., to each according to worth, to each according to need, to each according to contribution, etc., a value commonly held in Canada is that of equity. Equity is fairness according to need.

Application of the principle of distributive justice in health care means that all persons should have access to the necessities of life and health, and that those who are most disadvantaged may even deserve a greater share of resources. Discussions about resource allocation in health care occur at several levels: at the societal level in provincial government through budgets and policy initiatives; at the organizational level through decisions about programs; and at the individual level through decisions regarding care and treatment based on available resources. CARNA has articulated its beliefs about distributive justice in health care through the promotion of primary health care (CARNA, 2008a) and through lobbying efforts for fundamental health-care reform at the provincial level.

Approaches to Ethical Decision-Making: Three Illustrations

In this section, three different approaches to ethical action are explored. The scenarios are composite ones drawn from a variety of settings, real and imagined. None of the scenarios represents the actual events of any given situation reported to CARNA. Rather, each situation is constructed to represent, in a truthful manner, some of the ethical questions which nurses face in different ways across a variety of practice settings. The scenarios, which describe home-care and teamwork decisions, end-of-life decisions and decisions about safety respectively, reflect how situations can be approached differently. Each approach is offered as a possibility, not a prescription. Knowledge of the law, nursing practice standards, code of ethics, ethical principles, practice realities and of changing health-care organization, are sources of knowledge available for nurses to use as they work out their relationships with clients, colleagues and institutional personnel.

The intention of using a variety of approaches is to demonstrate that there is no one way of exploring situations. It is also important to recognize that the outcome of a particular ethical issue will depend on the particular people that are involved. This does not mean that ethical decisions are relative to personal opinions and beliefs; rather, it means that resolving issues is not done in the abstract. Ethical issues have to do with how to work out real life issues as they are lived through. It means that each situation will be different, depending on the relationships, principles, outcomes, responsibilities and commitments of each person with a stake in the eventual outcome.

Scenario I: A Question of Continuity

The following scenario addresses issues related to continuity of care in the restructured health-care system. It is used to illustrate the need to reflect on what constitutes ethical issues, as well as to consider approaches for taking action to resolve or deal with such issues.

Mrs. Olive Peterson

Mrs. Peterson is a lively eighty-seven-year-old woman who broke her hip while walking her dog on the slippery streets after a February rain. Following hospitalization for repair of her hip, she was discharged home with home-care services: physical therapy, weekly home-making help and daily personal care assistance from Care Services, a private agency. Meals on Wheels delivers food at noon daily. Coordination of services was arranged by a registered nurse, Rose Parker, case coordinator from the home-care agency.

Mrs. Peterson has been home for two weeks and is now able to ambulate only with great difficulty. She spends much of her time sitting in her chair. Her dog stays by her side, except for the daily walks provided by Nellie, the twelve-year-old girl next door. Mrs. Peterson's son and family, who live in a neighbouring town one and one-half hours away, are involved in arranging her care. Mrs. Peterson refused accommodation in any of the care facilities and demanded to be returned to her own home.

It is Friday at 7 p.m. Helen Jones, the health-care aide, visits Mrs. Peterson to assist with personal grooming, to help her into bed and to assist her through her range of motion exercises. Mrs. Peterson is watching a favourite television show and refuses to go to bed. She says she will do it by herself. Helen Jones, a casual employee with limited experience, has been told to do only what the client agrees to, as she is a visitor in Mrs. Peterson's home. She has never met this client before. While she tries to convince Mrs. Peterson to accept care, she finally leaves with Mrs. Peterson sitting in her chair. Because it is late, she cannot contact Rose Parker and does not have access to any other contacts. She decides to report this in the morning.

The concern: Mrs. Peterson, in wanting to be independent and self-sufficient, may not be able to see how her decision to refuse care could lead to a situation where she might harm herself and end up being even more dependent. Helen Jones, with her current level of experience and knowledge, may not realize that a vulnerable client does not always have all the required information or assistance to make such decisions. This example indicates the need for an interdisciplinary approach, with discussion and planning by the team as a whole. It may also need consideration by the administrative personnel.

How can this situation be explored by applying Ethical Principles?

A central principle to be considered for Mrs. Peterson is **autonomy**. In this situation, this principle refers to a respect for Mrs. Peterson's wish to make decisions for herself. Respect for autonomy is found in Helen Jones' decision to leave her in her chair. Two other important principles are **beneficence**, to act in the best interests of the client, and **non-maleficence**, to avoid harm and to protect from harm. If the understanding of harm

relates to immobility in the elderly, Helen Jones might feel obliged, in considering the best interest of the client, to carry out her responsibilities even to the extent of using forceful actions.

The principle of **distributive justice** also needs consideration. The fact that Helen has many other clients to care for this Friday evening may lead her to decide to either leave her client in her chair or to use persuasion or coercion to put her to bed. Applying the principles to the situation, and balancing one principle with the others, helps one decide what to do and to justify the position taken. This discussion leads us to the question of who is responsible for decision-making: Is it Mrs. Peterson? Is it her family? Is it Helen Jones? Is it Rose Parker as case co-ordinator? Who is responsible if harm results?

How does a focus on Relationships/Relational Ethics assist our ethical understanding of Mrs. Peterson's situation?

A relational approach may consider many questions not necessarily encountered in the principled approach. These questions might include:

- What time is appropriate to put elderly people to bed? Should all elderly people fit into that time frame?
- How can a system be made to accommodate the needs of Mrs. Peterson outside the traditional work hours?
- Who are the important or significant people in her life, and how does she want them involved in her care?
- What it is like to open your home and your life to strangers?
- How can one accept a statement of autonomy, such as "I can do this by myself" if one does not know this person? What are her abilities? And how would one know?
- Why does she not want to go to bed? Is it only the television program?
- How does the registered nurse maintain effective relations with both Mrs. Peterson and Helen Jones in assessing, implementing and evaluating the plan of care?
- How do we accommodate the client's needs and wants, as well as the worker's needs and wants?
- What are Mrs. Peterson's expectations? Of herself? Of the health-care system?

A relational approach would encourage the registered nurse, the health-care worker(s) and the client (and family), *together*, to consider appropriate action. Dialogue is the beginning of treatment itself, a conversation that needs to continue throughout the

provision of care (Storch, J. L., Rodney, P., & Starzomski, R., 2004). The context of health care, goals of care, consequences of action, external conditions and moral considerations are part of what would be discussed. Discussion will stimulate thinking, rather than provide one right answer. The caregiver(s) and the client (and family or friends) consider questions and begin to understand the issues as the dialogue continues. The dialogue would be complete (for the moment) when agreement/solution/action is taken. In the situation of Mrs. Peterson, Rose Parker as case co-ordinator would be the most probable person to encourage this sharing to occur. One might start with whatever area seems most appropriate; a variety of areas to consider are outlined below.

What are the goals of care? Are these goals shared by the client? The nurse? The health-care aide?

Some of the questions which Mrs. Peterson and her caregivers could consider under this area include the following:

- How does one respect autonomy? Or foster autonomy?
- How does one respect the client's decision-making ability or potential? What does she/he have to say? How can we hear and respect that voice?
- How can we know the client's best interests from his/her perspective, as well as from those of the providers?
- How can we best serve and respect needs of the client, the health-care aide and the nurse?

How is everyone affected? What are the consequences of action?

In all of the questions that are raised, it is recognized that each person responds and experiences the ethical dilemma from their own point of view. Everyone involved may want to consider:

- How is the client affected, considering her values, culture and expectations?
- How is the family affected, now and later?
- How is the health-care aide affected in her organization of work, working together with others, sorting out roles and traditions?
- How is the nurse affected by her decisions about delegating and supervising Mrs. Peterson’s care?
- How is society affected? What is the cost to society, institutions, organizations?
- How do we live with decisions and actions?

What other external conditions must be considered?

There are many other circumstances outside the immediate control of those involved with Mrs. Peterson which influence her care. These conditions can be identified by asking questions such as:

- What economic and political factors play a role in determining the allocation of resources within the system for Mrs. Peterson's nursing care?
- How free are people (given personal, cultural, economic and political circumstances) to voice their own wishes and make their own decisions?
- What knowledge does the registered nurse need to make safe judgments about Mrs. Peterson's care requirements? About the health-care aide's requirements for client-specific teaching, for supervision and for access to the advice of a registered nurse?
- What is the expectation of the health-care aide? What kind of knowledge does she need? What kind of knowledge (including emotional, intuitive, embodied) is valued?
- What are the risks for Mrs. Peterson, for the health-care aide and for the nurse in this situation? How can these risks be minimized? What is the definition of risk?
- What legislation applies to this situation in terms of agency ***obligations***, the nurse's obligations and the health-care aide's obligations? Who operates under a formal code of ethics and who does not?

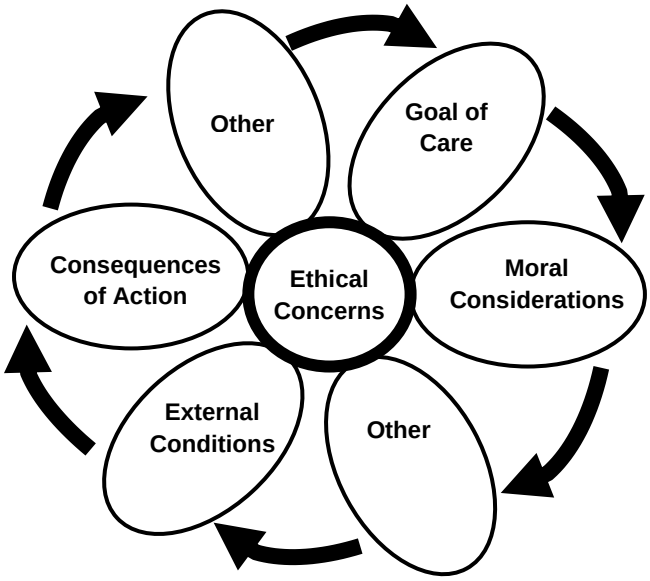
What other moral considerations (values) must be considered?

Other questions nurses frequently ask themselves in the process of ethical decision-making go to the heart of what we mean when we say "we want to do the right thing." These are questions like:

- How do we keep promises to clients?
- How honest can we be?
- How do we prevent harm, what kinds of harm concern us and why (e.g., creating helplessness)?
- How do we do good (e.g., in the other's best interest as they interpret it)?

A Model for Questioning

A model of ethical questioning in the image of a flower shows a process for viewing ethical problems in the context they are occurring and in relation to each other. Each petal of this flower would highlight a series of questions to be thought about in the situation. For example, one would ask a series of questions about external conditions until one felt that all issues had been uncovered and all the parties were satisfied that there were no more questions to ask. One would then travel around each petal using the same process of questioning. Petals could be added as other considerations and persons are involved. As the participants in this journey travel together in their decision-making they continually come back to the central *ethical concern* (which will change as the care progresses). The thinking about this issue will never follow the same path twice, as there will always be new information. It is not possible to know ahead of time what the solution will be, or that it is the only right one.



How would this model work in the situation of Mrs. Peterson?

In this model, the health-care team includes Mrs. Peterson as a participant. The team could start in the area of *moral considerations*: Would there be harm of leaving Mrs. Peterson alone? Yes, it could be harmful; she may fall helping herself, or if she stayed in her chair all night, she may have other problems. Would it be harmful to force her to bed? Yes, it could be harmful, especially if one thought that the use of force is always harmful. Moving to *external considerations*: The health-care aide is expected to visit five other clients before her shift is over at 10 p.m. - she needs to get this done. Should the

client fall again if she tried to get to bed herself, Helen Jones felt her job would be at risk. Is the allocation of resources for care adequate? What arrangements are in place for Helen to access Rose's counsel as needed, for this or any of her clients? What can Rose do if needed access has not been accounted for in the planning of resources?

What of the *consequences of action*? Mrs. Peterson is determined to be listened to. She wants to watch her favourite T.V. program at 8 p.m. Last week the attendant came at 9 p.m. and that worked so well. The night was not so long, and Mrs. Peterson was able to sleep through until early morning. Mrs. Peterson wondered if her neighbour would help her out this night. In consultation with the case co-ordinator, Helen agreed to stay until that arrangement could be made. Considering the *goal of care*: Having Mrs. Peterson take such a strong stance about her needs and wishes helped Helen to see that she was indeed getting stronger and able to be more independent. If she had known this client, or had some indication of her changing self-care abilities, the issue may not have come to a conflict. Further, a call to Rose might have been all that was required to problem solve the situation in a manner that considered everyone's needs. If all parties were prepared to consider this process, they may have returned to some of the other areas with increased understanding and knowledge. Of course if the situation were different, if Mrs. Peterson could not contact the neighbour to assist, or she was indeed more confused about her abilities, other outcomes would need to be considered.

The ethical principles of *respect for autonomy, do good (beneficence), do no harm (non-maleficence)* and *fairness* are involved in this discussion, but they are not the central focus. The focus is on the *relationship*, and on how to act out these principles in a participatory manner.

Scenario II: End-Of-Life Decisions

The following scenario examines several ethical issues that arise when the goal of services is the active, compassionate care of dying persons and those closest to them. Shared ethical principles are applied to this situation. Often there are important and difficult health care decisions to be made about health care treatment so having conversations with your family, friends and health care providers about advance care planning is important. These discussions are especially important for the elderly and for those people who have a chronic or terminal illness. However this kind of discussion should occur for all of us as one never knows when they might suddenly become ill or injured and unable to make their own decisions. There is legislation on personal directives and substitute decision-making in health care in the province of Alberta, which would be a legal consideration in this situation (*Personal Directives Act*, R.S.A. 2000 and the *Adult Guardianship and Trusteeship Act*, R.S.A. 2008).

Mr. Ralph Wells

A fifty-five-year-old man, Mr. Ralph Wells, who had been extremely active and managed his own business, suffered a massive cardiovascular accident (CVA). While the CVA rendered him unconscious, unable to move, incontinent and with no ability to communicate, he did not meet the brain death criteria. He was placed on life support with a poor prognosis for any further recovery. Four weeks later, he developed pneumonia. At that point, the issue of whether a feeding tube should be inserted was discussed.

The patient's wife insisted that all possible steps be taken. However, his children asserted that nature should take its course. They had voiced strong feelings that their father would not wish to lengthen his life under these circumstances or this way. The husband and wife were separated for some time prior to his illness, but were not divorced. The wife and children battled, with both parties threatening legal action should their wishes for Mr. Wells not be followed.

The patient's family doctor of twenty years came forward with a living will/personal directive which contained the standard provisions, including the refusal of any 'heroic means' and prolongation of life by artificial means. Although the living will was signed much earlier, Mr. Wells discussed his wishes in a general way with his family physician at his last check-up, and said that his wishes had not changed.

Analysis of Ethical and Legal Considerations

Autonomy and *self-determination* are basic ethical principles relevant to this situation. This man has even taken the step of putting his wish to refuse any treatment involving *heroic means* in writing. What would Mr. Wells regard as *heroic means* of intervention, either at the time this living will/personal directive was written or under his present circumstances? Many difficulties arise in the attempt to interpret this written wish in these circumstances. What kinds of treatment would this patient refuse if he could refuse today? Would he refuse the life support, but want to have his pneumonia treated? How much reliance can be placed upon this patient's previous lifestyle and values? Why did Mr. Wells choose to discuss this issue with his family physician, but have no direct discussions on this issue with either his spouse or with his children?

The principle of *distributive justice* is also important. Mr. Wells should be entitled to receive health care based upon need as covered by the Alberta Healthcare Insurance

Plan. However, Mr. Wells and his family represent a situation where the burden is great, both in terms of the possible suffering of the patient and in terms of the cost of care. The benefit appears small in light of both the poor prognosis and the strong possibility that Mr. Wells would refuse this intervention, were he able to speak. In situations where medical treatment has been started, the decision to withdraw treatment is often difficult.

How long should the treatment continue? Should certain time frames be established where continued intervention depends upon the patient's clinical response?

The ethical value of ***fidelity*** involves the quality of faithfulness and loyalty, or supporting the patient to the end. This quality is exhibited, although in a different form, by the children as well as the spouse. In addition, the health-care team will need to work together with the family as best they can to interpret the patient's wishes, to understand each person's relationship with Mr. Wells and to reach agreement on a reasonable plan of treatment. The conflict within the family is most difficult. It is not unusual that the person who has had the most distant relationship with the patient is the individual who insists on all steps being taken, even where this may seem of no benefit to the patient. Compassionate palliative care includes recognition of the family's need for time and support, as they each work through a changing relationship with someone they love.

The ethical principle of *beneficence* requires that the patient receive a positive benefit from the health-care intervention. This duty is difficult to assess in a situation where invasive treatment is already being provided. A decision must be made in the near future as to whether or not treatment of pneumonia should be initiated. Discontinuing the life support may not make any difference clinically at this stage. The pneumonia could probably be quickly treated, but would this patient see this as a benefit? What about inserting a feeding tube? Legally, a feeding tube is considered a medical intervention and the decision to insert a feeding tube must be made carefully to determine the benefits and burdens of this intervention. With treatment of pneumonia and food and fluid therapy, this patient may continue to survive indefinitely in this state. Failure to treat the pneumonia, combined with appropriate palliative measures, will probably result in a quick and painless death.

The patient's wish, as expressed in the living will, is consistent with the duty in regard to health care in these circumstances. There is no legal duty to provide extraordinary treatment. Extraordinary treatment usually means treatment which is futile or of no meaningful benefit to the patient. Therefore, there is no legal duty to start or continue treatment where there is no therapeutic benefit to the patient. If the patient's intent was to refuse the use of life support intervention in this circumstance, then life support would clearly be an assault and battery upon the patient, that is treatment which is without, or in this case against, the wishes of the patient.

A further ethical principle is that of *non-maleficence*, to do no harm. This is a difficult value to satisfy when the treatment being provided is extremely invasive, where the patient may be extremely uncomfortable (but this is difficult to assess), and where the persons who know the patient best are in strong disagreement as to the understanding

of the wishes of the patient. It is clear that continuing life support in these circumstances is against the wishes of the patient and should be stopped immediately, even with the threats of the spouse. Should the pneumonia be treated and should the feeding tube be inserted?

Where the wishes of the client cannot be ascertained with certainty, and where a surrogate decision-maker with legal authority does not exist, the best guideline for decision-making is usually the question of what is in the best interests of the client. This question is also difficult to answer in this situation.

Where no one has the legal authority to act on behalf of the client, the usual practice is that the decision is made in discussion with those who know the client best, that is, family members, and with the health-care team. The family doctor has known this patient for some time. The health-care team can provide detailed information in regard to the various options and the consequences of those choices for this patient.

In situations where a substitute decision-maker does not exist and the family members are in extreme disagreement, one option is an application for legal guardianship. This would then allow a court-appointed guardian to make the decision that the guardian views as being in the best interests of this individual.

Discussion of Options

The medical prognosis at four weeks after the CVA was that there was no hope of this client improving. The family was quite involved in grief and family counselling and pastoral care services, as well as numerous discussions with the health-care professionals caring for the client. It was clear to the professionals involved that life support should be immediately discontinued due to the client's refusal and the lack of benefit to the client. By respecting the family's need to arrive at that decision independently, the family and health-care team were eventually able to agree that the pneumonia should not be treated. A feeding tube was not initiated, in keeping with the dignity and wishes of this client. Mr. Wells died several days later in apparent comfort, with his wife in attendance. Counselling for the family continued for some time following his death.

There are several meaningful roles for registered nurses in providing nursing care at the end of life and in assisting individuals and families to achieve acceptable end-of-life choices (CNA, 2008b). The CNA *Code of Ethics for Registered Nurses* states that when people in their care are 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" (CNA, 2008a). Nurse

managers and clinicians can work with others in their settings, including clients and families, to formulate policy in this difficult area. Consultation through CARNA and a wider network of ethics expertise is available to assist in this important process. As the direct providers of care, staff nurses play a vital role in advocating needed communication between clients, families, caregivers and administrators.

Nurses can also facilitate better resolution of end-of-life issues by the dissemination and application of relevant research and information. A comprehensive bibliography on end-of-life, including such research, is available through the CARNA library.

Scenario III: Speaking Up For Safety

In the following scenario, the ethical decision-making of a group of registered nurses is described. These nurses were confronted with what they saw as an unacceptable proposal for nurse staffing in their rural acute care facility. This situation does not intentionally replicate any specific setting in Alberta. Inappropriate staffing patterns result in ratios of registered nurses to clients that may adversely affect the health outcomes of those receiving care.

Any registered nurse who believes that a policy or procedure is inconsistent with safe client outcomes is responsible for questioning that course of action. Questioning begins with accurate identification of the issue that poses real or potential harm to the welfare of clients. Often, one needs to consult with other colleagues and experts to determine what is unacceptable about the proposed practice, and to identify who must be involved to secure safe care. Every party to proposed policy or procedure changes shares responsibility for safe client outcomes; failure to question practices that one believes are unsafe is an ethical violation of the nurse's professional obligation towards those receiving care. Still, as the following scenario illustrates, speaking up for safety as an employee of an institution is an act which may involve several layers of ethical decision-making and personal risk.

Safety is a Bottom Line

In a rural acute care hospital, maternity and medical/surgical patients are on one unit. The staffing for this unit includes RNs and LPNs. Registered nurses are informed by their Administrator that as of Friday, the RN on the unit will be the back up for the RN in the Emergency department. The nurses are told that the LPNs will cover the unit when the RN is helping out in the ER, and will monitor laboring women and call the registered nurse in Emergency "whenever they think that the RN is required". Neither the physicians nor registered nurses have been consulted about the clinical implications of this proposed staffing pattern. LPNs expressed concern that the proposed staffing would leave them responsible for nursing judgment beyond their scope of practice.

Registered nurses need to consider several values central to their decision-making. They need to debate their relationships with and responsibilities towards their community, their individual patients and families, their fellow colleagues (*Collaborative Nursing Practice in Alberta*, 2003) and their own families. They also need to consider their ethical and legal obligations as registered nurses. Individual nurses can experience varying degrees of personal and collective risk associated with each successive step that is taken in addressing a safety concern, depending on their individual background, beliefs and commitments.

Process for Analysis of Ethical and Legal Considerations

The first step is to clearly identify the issue and the other stakeholders involved. In this scenario, the stakeholders would include the physicians, the LPNs, the Administrator, the facility's liability carrier for the institution and staff and the registered nurses' secondary source of liability coverage as employees, CNPS. This inclusive definition of stakeholders recognizes the importance of several relationships for registered nurses in the provision of care. In this scenario one could consider the community as a stakeholder as women and families expect to use the health services provided in this hospital.

For the registered nurses, defining what is at stake in the proposed staffing pattern might begin with determining current recommendations for the staffing of maternity and medical/surgical units in rural facilities. Advice on acceptable obstetrical staffing practices for client safety are available to nurses through the Alberta Perinatal Health Program, which advises physicians, nurses and other health-care providers on current research-based perinatal practice. Information gathered from the Alberta Perinatal

Health Program, other clinical experts in obstetrical nursing, the CARNA *Nursing Practice Standards*, the CNA *Code of Ethics for Registered Nurses* and CNPS can be used to document the concerns about the proposed staffing change to management. Concerns should be documented in terms of expected risks to the safe, competent, ethical nursing care of obstetrical clients and their families.

Documentation is an essential step in the process of addressing unsafe practice situations. Objective facts, dates, times, place, setting and people present should be stated. Documented concerns should be shared with fellow RNs, LPNs and physicians to determine common concerns about patient safety, areas of different opinion and to enable colleagues to get independent advice. The physicians may want to contact the College of Physician and Surgeons of Alberta and/or the Alberta Medical Association for advice both on liability and recommended standards of medical perinatal care. LPNs may want to contact the College of Licensed Practice Nurses of Alberta to discuss their concerns about responsibility.

After clear identification of the issue, acceptable outcomes for the concern should be determined. Registered nurses should provide their professional opinion on the specific outcomes or consequences for the client. CARNA's *Guidelines for Assignment of Client Care & Staffing Decisions* (2008b) can be used as a framework for identification and documentation of the problem. The registered nurses in this scenario may decide that for their community, what is at stake is informed consent to staffing changes that pose a potential risk to the provision of safe, competent, ethical nursing care of pregnant laboring women. For example, the optimal outcome could be to have continued staffing of the maternity and medical/surgical unit with a minimum of one registered nurse at all times when laboring women are present. If safe staffing could not be provided the minimal acceptable outcome could be discussion of closure of maternity services. Alternative ways or options for resource allocation decisions that minimize the potential to adversely affect client outcomes should be considered. This could encourage the development of alternate delivery models for cost-effective obstetrical care such as a community health center with birthing facilities and a multidisciplinary team of nurses, physicians and registered midwives.

Common concerns and recommendations should be presented to the Manager/Administrator. The written concern would clearly identify the issue, outline acceptable staffing patterns to allow for continuous registered nurse monitoring of women in labor, and cite clear timelines for satisfactory resolution of the concern. Documentation and communication on patient safety incidents should continue to be forwarded to the Manager/Administrator in a timely and accurate manner. This

continuous communication is intended to minimize risk to patients and to ensure the Manager/Administrator's accountability for staffing decisions consistent with safe patient care. In the absence of resolution with the Manager/Administrator the concerns should be presented jointly with other providers if possible, to those responsible at successive levels of policy-making.

The progress and the consequences for everyone should be reassessed at every step, in order to determine if the intended approach remains acceptable or if alternative strategies are required. Some nurses may be fearful for their own jobs in speaking up; others may be equally anxious about the consequences for patients if they do not pursue their concern to a satisfactory solution.

Ethical Principles

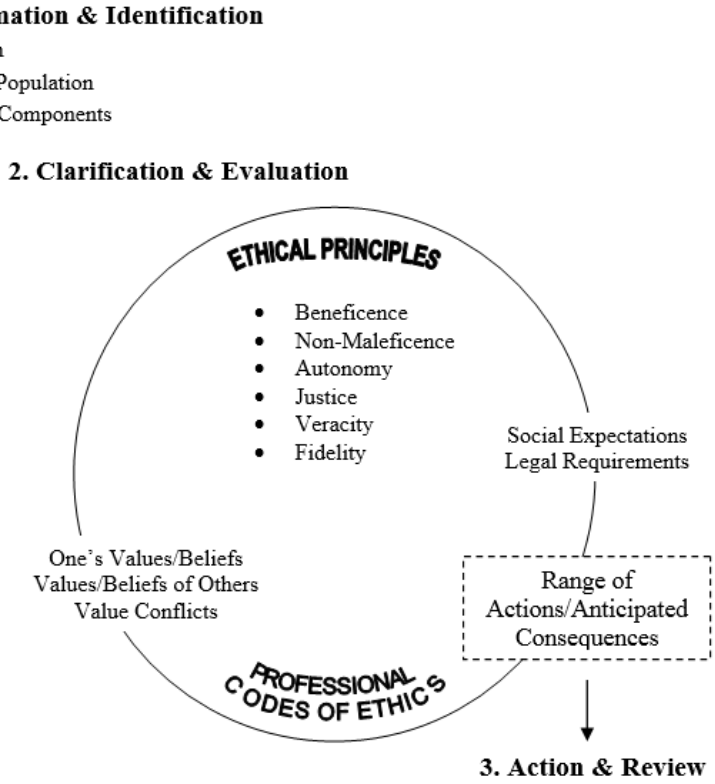
Concern for the ethical principles of *autonomy, beneficence, non-maleficence* and *distributive justice* are all apparent in various ways throughout the questions and actions that are explored in this scenario. Concern for their clients' right to choose obstetrical care on a fully informed basis demonstrates the valuing of each person's *autonomy*. The advocacy of quality care for their community, and for safe care regardless of personal cost, are evidence of commitment to *beneficence* and *non-maleficence*, respectively. Perhaps most significant for nurses collectively, would be the recognition of the role of *distributive justice* in this and other health-care dilemmas where resources are at issue. Nurses must work with their communities, governments and other professionals to advocate for appropriate allocation of resources that are associated with demonstrable health benefits.

One model for ethical decision-making which visualizes this expanding circle of ethical problems and possibilities is found in Storch's model (Storch et al., 2004) for the analysis of ethical issues, as reprinted here. In this model, the identification of ethical issues is filtered through a complex and connected web of personal, professional, social, ethical and legal considerations. The possibilities for action are linked to all of these factors in a continuous cycle that encourages professionals to anticipate consequences, to act with knowledge and to review options as many times as it takes to achieve an ethical outcome.

The registered nurses in this scenario may determine, both through their analysis and their actions, that for them and their community, safety was a bottom line that could not be ignored.

Model for Ethical Decision-Making

Note: From Toward a moral horizon: Nursing ethics for leadership and practice (p.515) by J. L. Storch, P. Rodney, & R. Starzomski (Eds.), 2004. Toronto: Pearson Prentice Hall. Copyright 2004 by Pearson Education Canada Inc.



Summary

In this document, the nature of ethics and its application to decision-making in health care is explored from the particular perspective of the nursing profession. Several scenarios are used to illustrate a variety of approaches to ethical decision-making for registered nurses. The intent of each approach is to recognize the complex array of relationships and choices which must be accounted for in any ethical question which surfaces in health care. All of the approaches are intended to support the core principles of self-governance, registered nurse responsibilities and accountabilities and accountability to the public.

Several CARNA documents which are central to ethical nursing practice are referenced and it is suggested that every registered nurse in Alberta review on initial registration. These include the *Health Professions Act* (2000) and the *Regulations Pursuant to the Health Professions Act*, the *Nursing Practice Standards* (2003) and the Canadian Nurses Association *Code of Ethics for Registered Nurses* (2008). Access to further CARNA documents and a wide range of literature on ethical issues is also available on the CARNA website or by contacting the provincial office library at 1-800-252-9392. Consultation on ethical issues is also available with CARNA Policy and Practice Consultants through the toll free number.

Registered nurses can foster ethical decision-making in health care, both system-wide and within their own practice, by using the resources available to them as a member of CARNA, and by taking an active part in the professional activities of the association.

Glossary

Autonomy – Self-determination; an individual's right to make choices about one's own course of action.

Belief – The conviction that something is true.

Beneficence – The principle that outlines a person's duty to act to benefit another.

Client – The person or persons receiving nursing care; can refer to patients, residents, families, groups, communities and populations.

Contractual model – Outlines the ethical obligations between individuals, based on a negotiated agreement that is to govern the terms of the relationship.

Covenant model – Outlines the ethical obligations that society has imposed between the health-care professional and client which go beyond the contract, such as the duty of continuing care or care in an emergency.

Distributive justice – The principle of fairness based on the equitable value of all individuals.

Duty – The obligation that one individual owes to another.

Ethical dilemma – Arises where two or more suitable actions of equal moral worth are options in a particular circumstance.

Ethical distress – Occurs when a practice is imposed on the professional despite their differing personal values and beliefs, resulting in feelings of guilt, concern or distaste.

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

Expert model – Ethical obligations which derive from the expertise of an individual.

Fidelity – The duty of faithfulness and loyalty.

Fiduciary model – Outlines ethical obligations between individuals that are based on legally imposed duties.

Friendship model – Outlines voluntary ethical obligations between individuals that are determined by the individuals.

Limitation – Describes exceptional circumstances in which a value or obligation cannot be applied.

Model – Example or description of the fundamental structure of a relationship.

Non-maleficence – Duty to do no harm and to protect others from harm.

Obligations – A directive which spells out what actions a value requires under particular circumstances.

Partnership model – Values and beliefs of individuals in a relationship are both shared and individual, and are related between the individuals in an equitable manner.

Paternalism – Making decisions for another based upon what an authority believes is best for that person.

Principle – A governing, foundational law of conduct to guide one's thinking and actions.

Relational ethic – A process for ethical reflection that allows consideration of the values, beliefs and wishes of all stakeholders in health care, clients and health-care professional, professional disciplines, employers and employees, governments and communities. They may differ and each will be acting from his own perspective.

Value – Something which is esteemed for its own sake.

Veracity – Duty to tell the truth.

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There is an extensive ethics bibliography available through CARNA and other libraries throughout the province. The CNA *Code of Ethics for Registered Nurses* includes an ethics reading resource section. Call CARNA at 1-800-252-9392 for more information.

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