Ethics in Professional Nursing Practice

3

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Nursing is a profession that has its own code of conduct, its own philosophic views, and its own place in the health care team. . . . Nurses work under their own license. That means that nurses are completely responsible for their work.

—Janet R. Katz, *A Career in Nursing: Is It Right For Me?*

OBJECTIVES

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

1. Differentiate nursing ethics from medical ethics and bioethics.
2. Delineate key historical events that led to the development of the current codes of ethics for the American Nurses Association (ANA) and International Council of Nurses (ICN).
3. Describe professional nursing boundaries and ways nurses cross those boundaries.
4. Review the concept of nursing as praxis.
5. Propose scenarios that require a stench test before the nurse can make an ethical decision.
6. Summarize the three major nursing ethical competencies: moral integrity, communication, and concern.
7. Discriminate among the ethical competencies that comprise each major ethical competency: (1) moral integrity: honesty, truthfulness and truthtelling, benevolence, wisdom, and moral courage; (2) communication: mindfulness and effective listening; and (3) concern: advocacy, power, and culturally sensitive care.
8. Contrast moral distress from moral integrity.
9. Recall ways to discern when a nurse fits Aristotle's description of the truthful sort.
10. Define truthtelling in relation to three ethical frameworks: deontology, utilitarianism, and virtue ethics.
11. Examine the nursing ethical implications involved when a physician, through exercising therapeutic privilege, does not disclose the whole truth to a patient who is in the process of dying with cancer.
12. Devise two or three scenarios that would prompt a nurse to respond with moral courage.
13. Describe the significance of communication in relation to the connection between mindfulness and effective listening.

OBJECTIVES

14. Relate patient advocacy and power to nurses' everyday ethical work.
15. Formulate an assessment plan for a culturally diverse patient who is newly admitted to a hospital.
16. Characterize two types of relationships: the nurse–physician relationship and the nurse–nurse relationship.
17. Explain how nurse recipients of horizontal violence progress to the walking wounded, then transform to the wounded healer.
18. Evaluate nurses' use of social networking in terms of the ANA guidelines for professional ethical conduct.
19. Imagine two or three incidents of social media use in which a nurse violated the ANA *Code of Ethics for Nurses with Interpretive Statements*.

Introduction to Nursing Ethics

Nursing professionals from the very early years constructed the meaning of nursing around ethics and ethical ways of caring, knowing, and acting. The meaning and scope of nursing ethics expanded as a result of unique nursing issues, but the road to a greater nursing voice has not been easy. Bioethical issues are relevant to nurses' work in everyday practice, yet in matters of bioethics nurses are not always autonomous decision makers.

During the birth of bioethics from 1947 to the 1970s, nurses' voices were left out of the dialogue of ethics. Complex ethical issues in medicine prompted in-depth medical ethics discourse among physicians, philosophers, and theologians. Pinch (2009) noted that

> mainstream ethics was slow to recognize and include the voices of nurses as both scholars and practitioners who faced innumerable dilemmas in health care. . . [but] this lack of widespread acknowledgement did not mean that the profession of nursing failed to address ethical issues in practice. (pp. 238–239)

Nurses began to place emphasis on particular ethical issues that stemmed from complicated bioethics, such as pain and suffering, relationships, and advocacy. In fact, nurses led the way in the 1980s in conducting empirical research on ethical issues (Pinch, 2009). These initiatives strengthened nursing's role in bioethics.

Today nurses in all roles engage in ethical decision making and behaviors arising from morality, relationships, and conduct issues surrounding patient care and in relationships with each other and other healthcare professionals. Some experts support the view of nursing ethics as distinctive from bioethics in other disciplines (Fry, Veatch, & Taylor, 2011; Holm, 2006; Volker, 2003; Wright & Brajtman, 2011). Additional views indicate everyday ethical practice in nursing as being situated within an interdisciplinary team.

Johnstone's definition of nursing ethics (2008) is consistent with the perception of a strong connection between nursing ethics and nursing theory, which distinguishes nursing ethics from other areas of healthcare ethics. Johnstone (2008) defined *nursing ethics* as "the examination of all kinds of ethical and bioethical issues from the perspective of nursing theory and practice, which, in turn, rest on the agreed core concepts of nursing, namely: person, culture, care, health, healing, environment and nursing itself" (p. 16).

The nursing profession embraces all of the roles that characterize nursing, whether in practice or not. Nursing ethics permeates all of those nursing roles. Nurses' professional relationships in patient care and within the healthcare team bring about ethical issues that are unique to nursing.

Effective *praxis in nursing* requires nurses make morally good decisions with indistinguishable means and ends to follow through with those decisions; nursing as praxis means ethics is embedded in practice and all activities of nursing. For everyday ethical decision making in work roles, nurses should begin by first referring to the *Code of Ethics for Nurses with Interpretive Statements* as a nonnegotiable guide for ethics (see Appendix B) then branch out for more support, as needed, to other literature and experts on the topic. Taking an ethical stance is always about justifying the chosen position by backing it up with support from codes of ethics, moral experts, and the premium and original literature on ethical topics; this position is threaded throughout this text. Moral philosophers argue in a highly complex structure in venues, such as in moral philosophy articles or verbally, for and against various issues. As nurses, it is not plausible to come to a strong justified position about an ethical dilemma or issue without substantially more in-depth reading and without wide-ranging consideration of the historical arguments within the moral philosophy and bioethical literature.

For good ethical decision making through praxis, nurses must be sensitive enough to recognize when they are facing seemingly obscure or uncomfortable ethical issues in everyday work. One such obscurity occurs when a nurse, such as a novice graduate, feels extreme pressure to conform to a hospital administrator's less than morally desirable decision over an action that would sustain the nurse's own moral integrity.

Research Note: Laabs's Study on New Graduates' Perceptions of Moral Integrity

In 2011 Laabs explored how newly graduated baccalaureate-prepared nurses perceive moral integrity and how prepared they feel to manage challenges. The new graduates described a person with moral integrity as a person practicing virtue ethics, "acting like, becoming, and being a certain kind of person who was honest, trustworthy, consistently doing and standing up for what is right, despite the consequences" but, paradoxically, they also perceived the expectations of administrators were for nurses "to set aside their values and beliefs and do what others ask, even if this would mean acting contrary to their conscience" (2011, p. 431). These confounding statements form a level of dissonance, which leads to moral distress and burnout. The ethical challenge for new nurses is learning how to maintain moral integrity and preserve mutual respect in an environment that trivializes and discounts nurses' work as an important contribution to care. Nurses who act contrary to their own values and beliefs to do what another person asks of them without questioning are at risk of becoming morally desensitized to their own conscience. Some nurses actually begin to think they will never be the kind of ideal, moral nurse they aspired to be.

Source: Laabs, C. (2011). Perceptions of moral integrity: Contradictions in need of explanation. *Nursing Ethics, 18*(3), 431–444.

Ethical Reflection

Kidder (1995) introduced nine checkpoints for ethical decision making. In his checkpoint for right versus wrong issues, he provided four ways for people to test for actions of wrongdoing. One way is the *intuition test*, also known as the *stench test*. Some actions or solutions do not pass a nurse's stench test. Nurses should test the stench by first asking this question: Does the intended action have a smell of moral wrongdoing, such as something a person feels not quite right, feels wrong or uncomfortable, has an air of corruption, or makes one cringe? If the answer is yes, nurses probably should not engage in the action. Nurses will develop a more intense moral sensitivity when they regularly practice ways to test for wrongdoing by way of intuition, or the gut.

Focus for Debate: Testing for Stench—Should You Set Aside Your Own Beliefs and Values?

Form two groups for a live or online classroom. Each group will provide a stance to the following question: Should you set aside your own beliefs and moral integrity values to carry out an action requested by an administrator? Suppose a transporter and an EMT dropped an unconscious patient to the floor during a transfer back to the nursing home. Deb, a new registered nurse in charge of this patient's care, witnessed the incident. A hospital nursing administrator under

extreme pressure for meeting safety performance benchmarks asked the nurse *not* to document the patient fall or file an incident report.

In your opinion, does this request pass the stench test? There are definite safety implications in this scenario, but putting aside the legal aspect for a moment, consider the ethical issues of truth versus deception, truth to self versus loyalty to the organization, or promoting good versus doing harm.

- One group will take the side favoring the nurse standing up for what she values as the moral and right thing to do, no matter what the outcome is.
- The next group will take the side of the administrator.

The members of each group will discuss the ethical issues. Spokespersons for each group will present and argue the group's position. The groups should constructively argue while discussing the ethical issues arising from the positions. Apply an ethical theory or framework for your justification. Get creative with your stance and rationale.

Professional Codes of Ethics in Nursing

Professional nursing education began in the 1800s in England at Florence Nightingale's school with a focus on profession-shaping ethical precepts and values. By the end of the 1800s modern nursing had been established, and ethics was becoming a discussion topic in nursing. The Nightingale Pledge of 1893 was written under the chairmanship of a Detroit nursing school principal, Lystra Gretter, to establish nursing as an art and a science. Six years later, in 1899, the International Council of Nurses (ICN) established its own organization and was later a pioneer in developing a code of ethics for nurses.

At the turn of the 20th century, Isabel Hampton Robb, an American nurse leader, wrote the first book on nursing ethics, titled *Nursing Ethics: For Hospital and Private Use* (1900/1916). In Robb's book, the titles of the chapters were descriptive of the times and moral milieu, such as the chapters titled "The Probationer," "Uniform," "Night-Duty," and "The Care of the Patient," which addressed nurse–physician, nurse–nurse, and nurse–public relationships.

The emphasis in the code was initially on physicians because male physicians usually trained nurses in the Nightingale era. Nurses' technical training and obedience to physicians remained at the forefront of nursing responsibilities into the 1960s. For example, the ICN *Code of Ethics for Nurses* reflected technical training and obedience to physicians as late as 1965. By 1973 the ICN code shifted from a focus on obedience to physicians to a focus on patient needs, where it remains to this day.

ANA *Code of Ethics for Nurses*

In 1926 the *American Journal of Nursing* (*AJN*) published "A Suggested Code" by the ANA, but the code was never adopted. In 1940 *AJN* published "A Tentative Code," but again it was never adopted (Davis, Fowler, & Aroskar, 2010). The ANA adopted its first official code in 1950. Three more code revisions occurred before the creation of the interpretative statements in 1976. The ANA added the word *ethics* to the publication of the 2001 code. The seventh edition, published in 2015, is the latest revision.

The ANA outlined nine nonnegotiable provisions, each with interpretive statements for illustration of detailed narratives for ethical decision making in clinical practice, education, research, administration, and self-development (see Appendix B for the ANA *Code of Ethics for Nurses with Interpretive Statements*). Deontology and normative ethics largely serve as the basis for the code. Although they are detailed enough to guide decision making on a wide range of topics, the interpretive statements are not inclusive enough to predict every single ethical decision or action in the process of nurses carrying out their roles. A clear patient focus in the code obliges nurses to remain attentive and loyal to all patients in their care, but nurses must also be watchful for ethical issues and conflicts of interest that could lead to potentially negative decisions in care and relationships with patients. Politics in institutions and cost-cutting strategic plans are among other negative forces in today's environment.

The ANA (2015) explored a variety of topics in the code: (1) respect for autonomy, (2) relationships, (3) patients' interests, (4) collaboration, (5) privacy, (6) competent practice, (7) accountability and delegation, (8) self-preservation, (9) environment and moral obligation, (10) contributions to the nursing profession, (11) human rights, and (12) articulation of professional codes by

Ethical Reflection: Code of Ethics Application

- In the *Code of Ethics for Nurses with Interpretive Statements*, the ANA (2015) currently emphasizes the word *patient* instead of the word *client* in referring to recipients of nursing care. Do you agree? Please explain your rationale.
- Take a few minutes to review the ANA *Code of Ethics for Nurses with Interpretive Statements* in Appendix B.
- After reviewing the interpretive statements in the code, create and discuss some random brief ethical issues on how nurses justify their actions using the following bioethical principles: autonomy, beneficence, nonmaleficence, and justice.

organizations. The interpretative statements illustrate many moral situations. For example, Provision 6 illustrates wisdom, honesty, and courage as essential virtues to produce an image of a morally good nurse. When these virtues are habitually practiced, they promote the values of human dignity, well-being, respect, health, and independence. These values reflect what is important for the nurse personally and for patients. Notable in the code is the reference to moral respect for all human beings, including the respect of nurses for themselves.

Another feature of the code is the emphasis on wholeness of character and preservation of self-integrity. *Wholeness of character* relates to nurses' professional relationships with patients and a recognition of the values within the nursing profession, one's own authentic moral values, integration of these belief systems, and expressing them appropriately. *Personal integrity* involves nurses extending attention and care to their own requisite needs. Many times nurses who do not regard themselves as worthy of care cannot give comprehensive care to others. Recognizing the dignity of oneself and of each patient is essential to providing a morally enhanced level of care.

ICN *Code of Ethics for Nurses*

In 1953 the ICN adopted its first code of ethics for nurses (see Appendix C for the 2012 ICN *Code of Ethics for Nurses*). The multiple revisions illustrate the code is a globally accepted document for ethical practice in nursing. Since 1953 nurses in many countries have adapted the ICN code. The fundamental responsibilities of promoting health, preventing illness, restoring health, and alleviating suffering emanates from the role of nursing. The code serves as an action-based standard of conduct related to four key elements: nurses and people, nurses and practice, nurses and the profession, and nurses and coworkers. Similar to the ANA code, the elements in the ICN code form a deontological, normative ethics framework for nurses to internalize before using it as a guide for nursing conduct in practice, education, research, and leadership.

Common Threads Between the ANA and ICN Codes

Common threads exist between the nine provisions of the ANA code (2015) and the four elements of the ICN code (2012). The codes, which apply to all nurses in all settings and roles, are nonnegotiable ethical nursing standards with a focus on social values, people, relationships, and professional ideals. Both codes share values such as respect, privacy, equality, and advocacy.

Nurses should protect the moral space in which patients receive care, and they should uphold the agreement with patients on an individual and collective basis. Protecting the moral space of patients necessitates nurses provide

compassionate care by endorsing the principles of autonomy, beneficence, nonmaleficence, and justice. Within the codes, nursing responsibilities include promoting and restoring health and preventing illness, but a significant emphasis is alleviating suffering of patients who experience varying degrees of physical, psychological, and spiritual suffering.

Professional Boundaries in Nursing

Professional ethical codes serve as useful, systematic, normative guidelines for directing and shaping behavior. The ANA and ICN codes apply to all nurses regardless of their roles, although no code can provide a complete and absolute set of rules free of conflict and ambiguity, which is a rationale often cited in favor of the use of virtue ethics as a better approach to ethics (Beauchamp & Childress, 2012).

Some people believe that nurses who are without a virtuous character cannot be depended on to act in good or moral ways, even with a professional code as a guide. In the 30th anniversary issue of the *Journal of Advanced Nursing*, the editors reprinted a 1996 article by Esterhuizen (2006) titled "Is the Professional Code Still the Cornerstone of Clinical Nursing Practice?", and the journal solicited comments from three contributors for the reprinted article. This information is most relevant today. One respondent, Tschudin (2006), agreed with Esterhuizen that nurses lack opportunities for full autonomy in moral decision making. There is abundant ground for nurses to engage in moral decisions, but they still do not have enough opportunity to participate. In the current uncertain moral landscape, nurses often wonder about the benefit of codes of ethics. Tschudin's key message was when virtuous nurses experience full autonomy and accountability, they have an internal moral compass to guide their practice and do not necessarily need a code of ethics for guidance.

However one perceives the value of codes of ethics for nurses, they still serve as mandates for accountability in all roles of nursing, whether in practice or not. *Professional boundaries* are limits that protect the space between the nurse's professional power and the patient's vulnerabilities. Boundaries facilitate a safe connection because they give each person in the relationship a sense of legitimate control, whether the relationships are between a nurse and a patient, a nurse and a physician, a nurse and an administrator, or a nurse and a nurse. The National Council of State Boards of Nursing (NCSBN) (2011a) explained the power of a nurse as follows:

> The power of the nurse comes from the professional position, the access to private knowledge about the patient and the patient's need for care. Establishing boundaries allows the nurse to control this power differential and allows for a safe interaction to best meet the patient's needs. (National Council of State Boards of Nursing [NCSBN], para. 2)

The blurring of boundaries between persons in a relationship is often subtle and unrecognizable at first. Even so, two distinct types of departures from

professional boundaries occur. The first type of departure is *boundary violations*, which are actions that do not promote the best interest of another person in a relationship and pose a potential risk, harm, or exploitation to another person in the relationship. Boundary violations widely vary, from misuse of power, betrayal of trust, disrespect, and personal disclosure to more severe forms, such as sexual misconduct and exploitation. The second type of departure, *boundary crossings*, is a lesser and more short-lived type that accidentally or intentionally occurs during normal nursing interventions and will not necessarily happen again. The ANA (2015) included numerous boundary issues in its code of ethics. Social media boundary issues are presented later in this chapter in the section on social media.

The obvious question is how nurses know when they have crossed a professional boundary. In 2003, Maes asked oncology nurses this question. Years later, some of their responses are still relevant for today's nurses. Maes observed the line in the sand is blurry.

In addition to the ethical guidelines in the code of ethics, nurses also must follow the board of nursing's legal regulations and standards for practice in his or her state of residence. Every country has its own code of ethics, and each state and country has a set of legal rules and regulations for nursing practice. Each state

Ethical Reflection: Professional Boundaries and Moral Obligations for Nurses

The following professional boundaries and moral obligations for nurses are specified by the ANA *Code of Ethics for Nurses with Interpretive Statements* (2015).

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–nurse relationships, nurse–physician relationships, nurse–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

Ethical Reflection: Professional Boundaries and Moral Obligations for Nurses (continued)

- Advancing knowledge and research through professionalism, practice, education, and administrative contributions
- Collaborating with other healthcare professionals and the public to promote community and 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

Source: American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.

board of nursing is "responsible for enforcing the nurse practice act to promote safe and competent care" (NCSBN, 2011c, Introduction). Violations can result in voluntary surrender, suspension, or revocation of a nurse's license and prohibition from practice. The boards of nursing function not to protect nurses, but to protect the public and ensure safe and competent patient care. Refer to state

Ethical Reflection: How Do Nurses Know When They Have Crossed a Professional Boundary?

Maes (2003) interviewed several oncology nurses to ask them how they know when they have crossed a professional boundary. Their comments are provided in the following list. All of these nurses discussed the difficulty of trying not to cross boundaries:

- Emily Stacy, a hospice nurse, stated, "One danger sign could be when you 'dump' your own problems and stressors on patients or their family members because you feel close to them" (2003, p. 4).
- Jane Hawksley, a nurse manager, added, "New nurses have not developed their own boundaries yet, this can lead to a slippery slope of sympathy versus empathy, making crossing the line easy to do. Usually the red flag is there . . . [so] be aware of your internal responses, and, if in doubt at all, check it out because these responses are a red flag that need to be understood" (2003, pp. 5–6).
- Barb Henry, a psychiatric nurse practitioner, provided a description of dumping problems on patients: "My job is to help patients deal with their 'black clouds.' On one visit, I was carrying around my own black cloud and was really focused on it. The patient innocently asked me a question related to the issue, and I ended up sharing my black cloud. . . . The boundary line is difficult to maintain" (2003, pp. 4–5).

Source: Maes, S. (2003, August). How do you know when professional boundaries have been crossed? *Oncology Nursing Society, 18*(8), 3–5.

boards of nursing websites for examples of how boundary violations result in the suspension or revocation of a nurse's license.

Legal suits are less likely to be filed if patients distinguish nurses as caring, compassionate, kind, and respectful (Diemert, 2012). If patients or families file legal suits of negligence or malpractice in a civil court against a nurse, the plaintiff's lawyer must prove injury or harm to the plaintiff as a result of the nurse's negligence or malpractice. *Negligence* is failure of the nurse to give care as a reasonably prudent and careful person would give under similar circumstances. *Malpractice* is improper or unethical conduct or unreasonable lack of skill by a nurse or other professional that results in damages.

Ideal Nursing Ethical Competencies

The ethical competencies identified in this section tend to be interrelated in meaning, yet each has a degree of distinctiveness. Together they characterize a well-defined, ideal nurse. This section comprises 13 competencies divided into 3 major categories: (1) moral integrity: honesty, truthfulness and truthtelling,

Legal Perspective: Categories of Negligence That Lead to Malpractice Lawsuits

Nurses increasingly are named defendants in malpractice lawsuits. From 1998 to 2001, the number of payments for nursing malpractice lawsuits increased from 253 to 413. Even though nursing educators have made strides in educating nursing students about legal responsibilities, safe care and actions, and limitations, Croke (2003) argued there are no signs of a decrease in malpractice suits because of numerous factors, including the following: (1) delegating too much and inappropriately, (2) discharging patients too soon, (3) nursing shortages and hospital downsizing, (4) increasing responsibility and autonomy of nurses, and (5) patients being more informed and families having higher expectations for safe care.

In an analysis of legal cases between 1995 and 2001, Croke (2003) outlined six categories of nursing negligence that result in malpractice suits:

- Failure to follow standards of care
- Failure to use equipment in a responsible manner
- Failure to communicate
- Failure to document
- Failure to assess and monitor
- Failure to act as a patient advocate

Source: Croke, E. M. (2003). Nurses, negligence, and malpractice: Continuing education. *American Journal of Nursing, 103*(9), 54–63.

benevolence, wisdom, and moral courage; (2) communication: mindfulness and effective listening; and (3) concern: advocacy, power, and culturally sensitive care.

Moral Integrity

The foremost ethical competency is moral integrity, a virtue often considered the fiber of all other virtues. Most of the time when people speak of a person's moral integrity, they are referring to the quality and wholeness of character, which is why some believe moral integrity is necessary to realize full human flourishing. Plante (2004) stated that although no one is mistake free, people with moral integrity follow a moral compass and usually they do not vary by appeals to act immorally. A person with moral integrity manifests a number of virtues. Presented in this section are five of those virtues: honesty, truthfulness and truthtelling, benevolence, wisdom, and moral courage. Moral distress is also presented in this section, not as a virtue, but as a problem related to nurses feeling constrained by their workplace to follow a path of moral integrity in their actions.

People with moral integrity pursue a moral purpose in life, understand their moral obligations in the community, and are committed to following through regardless of constraints imposed on them by their workplace policies. In Laabs's (2011) qualitative study, nurses' described *moral integrity* as a "state of being, acting like, and becoming a certain kind of person. This person is honest, trustworthy, consistently doing the right thing and standing up for what is right despite the consequences" (2011, p. 433).

Features of moral integrity include good character, intent, and performance. Said another way, nurses of good character consistently use their intellectual ability and moral propensity accompanied by pragmatic application to execute good and right actions.

Moral Distress Nurses' work involves hard moral choices that sometimes cause moral distress, resulting in emotional and physical suffering, painful ambiguity, contradiction, frustration, anger, guilt, and an avoidance of patients. Moral distress occurs when nurses experience varying degrees of compromised moral integrity. Jameton (1984) popularized and defined the term *moral distress* as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Since Jameton's initial work, authors have continued to research and develop the conception of moral distress.

Nurses are susceptible to moral distress when they feel pressure to do something that conflicts with their values, such as to falsify records, deceive patients, or subjected to verbal abuse from others. Moral distress, which is an internal experience

opposite to feelings associated with a sense of moral integrity, occurs when nurses or other healthcare professionals have multiple or dual expectations and cannot act according to their proclivity toward moral integrity. When a situation forces nurses to make a decision compromising their moral integrity, the decision, in the end, may or may not have interfered with their ethical stance and structure.

Many times nurses' moral distress stems from system demands on them to act otherwise. In a healthcare system often burdened with constraints of politics, self-serving groups or interests, and organizational bureaucracy, threats to moral integrity can be a serious pitfall for nurses. Research indicates these environments have a strong effect on the degree of nurses' moral distress (Redman & Fry, 2000). Numerous scholars have linked moral distress to incompetent or poor care, unsafe or inadequate staffing, overwork, cost constraints, ineffective policy, futile care, unsuccessful advocacy, the current definition of brain death, objectification of patients, and unrealistic hope (Corley, 2002; Corley, Minick, Elswick, & Jacobs, 2005; McCue, 2011; Pendry, 2007; Schluter, Winch, Holzhauser, & Henderson, 2008).

Leaders of nursing continue to search for strategies to reduce moral distress and promote healthy work environments. The American Association of Critical-Care Nurses (2008) published a position statement to accentuate the seriousness of moral distress in nursing:

> Moral distress is a critical, frequently ignored, problem in health care work environments. Unaddressed it restricts nurses' ability to provide optimal patient care and to find job satisfaction. AACN asserts that every nurse and every employer are responsible for implementing programs to address and mitigate the harmful effects of moral distress in the pursuit of creating a healthy work environment. (p. 1)

Four years earlier the AACN ethics work group developed a call-to-action plan titled *The Four A's to Rise Above Moral Distress* (2004). Nurses use the Four A's plan as a guide to identify and analyze moral distress:

- *Ask* appropriate questions to become aware that moral distress is present.
- *Affirm* your distress and commitment to take care of yourself and address moral distress.
- *Assess* sources of your moral distress to prepare for an action plan.
- *Act* to implement strategies for changes to preserve your integrity and authenticity.

Preventing moral distress requires nurses to recognize the at-risk dynamics and issues. An environment of good communication and respect for others is essential for decreasing the likelihood of experiencing moral distress.

Honesty

A virtue of moral integrity is the ethical competency of honesty. In the 2013 Gallup Politics poll, as in other years, nurses were rated as the most honest and ethical healthcare professionals, except in 2001 (as cited in Swift, 2013). Nurses have earned this trust because of their commitment and loyalty to their patients. According to Laabs (2011), nurses identify honesty as important for three reasons: (1) honesty is a prerequisite for good care, (2) dishonesty is always exposed in the end, and (3) nurses are expected to be honest.

In a phenomenological study of nurses on honesty in palliative care, nurses sometimes had difficulty defining honesty (Erichsen, Danielsson, & Friedrichsen, 2010). In an attempt to clarify nurses' perceptions of honesty, they often defined lying or dishonesty as sharp contrasts to honesty. Nurses perceived honesty as a virtue related to facts, metaphors, ethics, and communication, and they perceived truthtelling as a palpable feature in trusting relationships.

Honesty, in simple terms, is being "real, genuine, authentic, and bona fide" (Bennett, 1993, p. 597). Honesty is more than just telling the truth; it is the substance of human relationships. Honesty in relationships equips people with the ability to place emphasis on resolve and action to achieve a just society. People with a mature level of honesty dig for truth in a rational, methodical, and diligent way while placing bits of truths into perspective and prudently searching for the missing truths before addressing the issue. In other words, honesty is a well thought out and rehearsed behavior that represents commitment and integrity.

There are many ways that nurses portray honesty, such as staying true to their word. Nurses must stay committed to their promises to patients and follow through with appropriate behaviors, such as returning to patients' hospital rooms as promised to help them with certain tasks. If nurses do not follow through with their commitments, trust may be broken, and patients potentially will see those nurses as dishonest or untrustworthy.

Honesty is also about being honest with one's self. Nurses need to establish a routine checkpoint system of ongoing self-evaluation to retain and improve honesty in actions and relationships with patients and others. For example, if a nurse is in the process of administering medications and a pill falls on the hospital floor, would the nurse be justified in wiping it off and placing it back in the cup if no one was there to see the action? Nurses might be tempted to wipe off the pill and administer it just to keep from completing a required form for a replacement medication, but if nurses evaluate their situations and make decisions based always being honest with oneself, it is more likely they will make rational, trustworthy decisions regarding the care of patients.

Truthfulness and Truthtelling

The next virtue of moral integrity is the ethical competency of truthfulness. Aristotle identified 12 excellences of character, or virtues, in his book *Nicomachean*

Ethical Reflection: Aristotle's Truthful Sort

> We are not here talking about the person who tells the truth in the context of agreements, or anything of that sort . . . but about contexts in which . . . a person is truthful both in the way he talks and in the way he lives, by virtue of being such by disposition. Someone like this would seem to be a decent person. For the lover of truth, since he also tells the truth where it makes no difference, will tell the truth even more where it does make a difference; for there he will be guarding against falsehood as something shameful, when he was already guarding against it in itself. Such a person is to be praised. (Rowe & Broadie, 2002, p. 155)

Source: "Ethics Nicomachea" translated by Ross from ETHICS from The Oxford Translation of Aristotle, edited by W.D. Ross, Volume 9, 1925, pp. 141–157. By permission of Oxford University Press.

Ethics (Rowe & Broadie, 2002). A virtue is an intermediate state between two extremes: excessiveness and deficiency. Truthfulness, then, is the intermediate state between imposture (excessiveness) and self-deprecation (deficiency). Truthfulness is being genuine in all words and deeds and is never false or phony. A truthful person speaks in a way that symbolizes who the person really is. Aristotle explained his view of a truthful person as being *the truthful sort*.

Based on the principle of veracity, truthfulness is what we say and how we say it. *Truthfulness*, translated to *truthtelling* in the healthcare environment, means nurses are usually ethically obligated to tell the truth and are not intentionally to deceive or mislead patients, which relates to the authentic, not fake, person in the context of Aristotle's truthful sort. Because of the emphasis in the Western world on patients' right to know about their personal health care, truthtelling has become the basis for most relationships between healthcare professionals and patients (Beauchamp & Childress, 2012). In the older traditional approach, disclosure or truthtelling was a beneficent or paternalistic approach with actions based on answers to questions such as, "What is best for my patient to know?"

Today the ethical question to ask is, "Are there ever circumstances when nurses should be morally excused from telling the truth to their patients?" The levels of disclosure in health care and the cultural viewpoints on truthtelling create too much fogginess for a clear line of distinction between nurses telling or not telling the truth. The ANA *Code of Ethics for Nurses* (2015) obligates nurses to be honest in matters involving patients and themselves and to express a moral point of view when they are alert to any unethical practices.

In some Western cultures, such as in the United States, autonomy is so valued that withholding information is unacceptable. Under this same autonomy principle it is assumed patients also have a right *not* to know their medical history if they so desire. Some cultures, such as those in some Eastern countries, do not prize autonomy in this way; the head of the family or the elders usually decide how much and what information needs to be disclosed to the family member as patient.

Therapeutic Privilege The American Medical Association (AMA) (2006) published a statement on the definition of *therapeutic privilege* and offered an explanation of its moral meaning. The following excerpt spotlights this opinion:

> The practice of withholding patient medical information from patients in the belief that disclosure is medically contraindicated is known as therapeutic privilege. It creates a conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully. Therapeutic privilege does not refer to withholding medical information in emergency situations, or reporting medical errors.
>
> Withholding medical information from patients without their knowledge or consent is ethically unacceptable. Physicians should encourage patients to specify their preferences regarding communication of their medical information, preferably before the information becomes available [but] physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy. . . .
>
> All information need not be communicated to the patient immediately or all at once; physicians should assess the amount of information a patient is capable of receiving at a given time, delaying the remainder to a later, more suitable time, and should tailor disclosure to meet patients' needs. (para. 1–3)

When physicians exercise this privilege, they base their opinion on facts gathered from the patient's records and their interactions with the patient, family, and other healthcare professionals. Some reasons nurses or physicians might avoid telling the full truth include the following: (1) they are trying to protect patients from sad and heartbreaking news, (2) they do not know the facts, or (3) they state what they know to be untrue about the situation rather than admit everything they know to be true.

There are advantages for physicians and nurses to tell the truth, especially when patients are in advanced stages of a diagnosis (Loprinzi et al., 2010). With the full knowledge of the disease process, patients will make fully informed decisions, be prepared for the outcomes, have more meaningful dialogue with family members, and make the most of meaningful events during their remaining life. Nurses have a difficult decision to make, especially when a patient wants to know the full truth and physicians have decided to disclose only part of the truth—or none of it—to the patient. No matter how disappointing the news will be to patients and families, nurses must evaluate each situation carefully with wisdom and contemplation before making any decision on the degree of disclosure. A clear understanding of the transpired communication between the physician, patient, and family members contributes to the nurse's decision on the degree of shared disclosure.

An excellent example of truthtelling is from the play *Wit* by Margaret Edson, winner of the 1998 Pulitzer Prize. The play was published as a book in 1999, then

Ethical Reflection: A Woman with Uterine Cancer

You are the nurse caring for a woman scheduled for a hysterectomy because of uterine cancer. The community knows her surgeon as having a bad surgical record in general, but especially in performing hysterectomies. The woman previously heard gossip to this effect and asks you about it before her surgery because she is apprehensive about using the surgeon. You know at least one legal suit has been filed against him because you personally know the woman involved in a case of a botched hysterectomy.

Your choices are as follows: (1) you could be brutally honest and truthful with your preoperative patient; (2) you could be part truthful by giving her correct information on certain pieces of the gossip to clarify misconceptions, but remaining silent on other parts of the gossip you know could be damaging; or (3) you could be totally untruthful by remaining silent or by telling her you have heard nothing.

- Discuss these options and any other ideas you may have regarding this case. As a nurse who wants to be committed to an ethical nursing practice, what actions might you consider in this difficult circumstance? Be as objective as possible.
- Now that you have determined possible actions, please justify these actions by applying either Kant's deontological theory, utilitarian theory, or a virtue ethics approach.
- Describe the major differences, or any similarities, among these three frameworks (deontology, utilitarianism, and virtue ethics).
- Other than simply telling the truth verbally to patients and others, how else can you display your honesty and truthful sort in ethical nursing practice? Imagine how you would portray honesty in different settings and situations, such as patient care and family relationships, documentation, safe care, and relationships with coworkers and administrators, while taking into consideration the moral obligations delineated in the ANA *Code of Ethics for Nurses with Interpretive Statements*.

made into an HBO Home Movie in 2001, and it is available for purchase. Susie Monahan, the registered nurse caring for Vivian Bearing, decided to tell the truth to and be forthright with a patient despite a few physicians who chose not to do so.

Benevolence

The ethical competency of benevolence is another virtue of moral integrity. *Benevolence* is a "morally valuable character trait, or virtue, of being disposed to act to benefit others" (Beauchamp, 2013, Part 1, para. 2). Some people believe benevolence surpasses the act of compassion. Confucianists place a high priority on human character, or virtuous conduct. They view benevolence as the highest-ranking, perfect virtue with the greatest degree of influence; the ideal morality is for benevolence to prevail in the world (Hwang, 2001). Altruistic, kindhearted, caring, courteous, and warmhearted are characterizations of a benevolent person; also, in definitions of compassionate care, kindness and benevolence, among others, are common descriptors.

The bioethical principle of beneficence and the virtue of benevolence are similar, but they are not necessarily connected. Benevolence refers to the

Ethical Reflection: A Case of Truthtelling

Susie Monahan, in the book and movie *Wit*, was a registered nurse caring for Vivian Bearing, a patient who was dying of cancer, at a large research hospital. Vivian was getting large doses of cancer chemotherapy without any success of remission. In fact, the cancer was progressing at an alarming rate. She was near death, but the research physicians wanted to challenge her body with chemotherapy for as long as possible to observe the outcome effects. Everyone on the staff had been cold, indifferent, and technically minded, and no one had shown any concern for Vivian except for Susie. Vivian had not been informed about the chemotherapy failure, her prognosis, or the likelihood of her dying. One night Susie found Vivian crying and in a state of panic. Susie first helped to calm her, and then she shared a popsicle with Vivian at the bedside while she disclosed the full truth to Vivian about her chemotherapy, her prognosis, her choices between Code Blue or DNR, and her imminent death. Susie affectionately explained,

> You can be "full code," which means that if your heart stops, they'll call a Code Blue and the code team will come and resuscitate you and take you to Intensive Care until you stabilize again. Or you can be "Do Not Resuscitate," so if your heart stops we'll . . . well, we'll just let it. You'll be "DNR." You can think about it, but I wanted to present both choices." (Edson, 1999, p. 67)

Susie felt an urge to be truthful and honest. By demonstrating respect for Vivian, Susie was showing her capacity to be human.

Source: Edson, M. (1999). *Wit*. New York, NY: Faber & Faber.

propensity and desire to act to benefit others, which often prompts beneficent acts. Throughout nursing's history, nurses have placed a high importance on benevolence, or kindness. Pearce (1975), a past nursing tutor and author of the 1937 edition and many subsequent editions of *A General Textbook of Nursing*, described a benevolent scenario:

> Nurses soon learn to realize the value of a pleasing professional approach and the occasional glance in passing, nod of the head or smile takes no time and makes a valuable contribution to good relationships. Communication need not always be verbal, and the nurse by the exercise of her skills can convey sympathy and assurance to a patient who may be too weary or ill to listen to much conversation. (1975, p. 4)

More than 2 decades ago but still relevant today, Lutzén and Nordin found in their research (1993) that nurses described benevolence as a central motivating factor in nursing decision making and actions.

Research Note: Benevolence as a Central Moral Concept—a Grounded Theory Approach to Research

Lutzén and Nordin (1993) used a grounded theory research design to explore moral decision making in psychiatric nursing practice. Fourteen seasoned nurses from Sweden participated in the study by way of interviews. After transcribing and coding the data into several categories, Lutzén and Nordin discovered that benevolence was a category with important merit because nurses characterized it as a central motivating factor for making everyday decisions with and for the patients. The researchers placed descriptions such as "have always loved other people," "being close to," and "being really close to a patient, to share his sorrow" within the category of benevolence.

Source: Lutzén, K., & Nordin, C. (1993). Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings. *Journal of Advanced Nursing, 18*, 1106–1111.

The foundational concepts of nursing include doing good, promoting acts to benefit others, and preventing harm, or doing no harm. Nurses who use benevolence as a central motivating factor do not just perform acts of kindness in a haphazard fashion when the opportunity arises; they seek out ways to perform acts of kindness rather than only recognizing ways to do good.

Wisdom

Another virtue of moral integrity is the ethical competence of *wisdom*, often called practical wisdom, and it requires calculated intellectual ability, contemplation, deliberation, and efforts to achieve a worthy goal. Aristotle believed wisdom is an excellence of genuine quality that develops with intellectual accomplishment, or *sophia*, and practical expertise, or *phronesis* (Broadie, 2002). People are said to be wise if they successfully calculate ways to reach a worthy goal or end. The ultimate goal of happiness comes only from exercising rational and intellectual thinking, which is a product of wisdom and contemplation. Aristotle considered good deliberation as a necessary mindful process toward reaching a worthy end or goal. He said, "So in fact the description 'wise' belongs in general to the person who is good at deliberation . . . nobody deliberates about what things cannot be otherwise, or about things he has no possibility of doing" (Rowe, 2002, p. 180).

Aristotle's viewpoint, in summary, is people cannot achieve their worthy goals or ends, or be considered wise, unless they develop both features that comprise the virtue of wisdom, but only through a significant amount of deliberation and contemplation. As previously stated, the two features of wisdom are intellectual accomplishment and practical expertise.

Aristotle's conception of wisdom fits with nursing and medical practice. Pellegrino and Thomasma (1993), who are medical philosophers, cited *phronesis* (practical wisdom) as medicine's indispensable virtue, and they also discussed the virtue of *prudence* (wisdom) as a necessary extension to *phronesis* in order to help people "discern, at this moment, in this situation, what action, given the uncertainties of human cognition, will most closely approximate the right and the good" (1993, p. 85).

People with prudence have the feature of intellectual accomplishment *and* the proclivity to seek the right and the good. Nurses must also develop this combination. *Clinical wisdom* is sometimes cited to describe the necessary combination of prudence and practical wisdom. Benner, Hooper-Kyriakidis, and Stannard (1999) described this type of connection as clinical judgment and clinical comportment, both of which require nurses to continually reflect upon the present situation in terms of the "immediate past condition of the patient" (p. 10). Clinical judgment and clinical comportment encompass six areas that serve as a guide for active reflection in nursing practice: "(1) reasoning-in-transition; (2) skilled know-how; (3) response-based practice; (4) agency; (5) perceptual acuity and the skill of involvement; and (6) the links between clinical and ethical reasoning" (1999, p. 10).

Moral Courage

The next virtue of moral integrity is the ethical competence of moral courage, which is highly valued and seems to be inherent in nursing. Nurses with *moral courage* stand up for or act upon ethical principles to do what is right, even when those actions entail constraints or forces to do otherwise. Moral courage turns into noticeable actions. If nurses have the courage to do what they believe is the right thing in a particular situation, they make a personal sacrifice by possibly standing alone, but they will feel a sense of peace in their decision. If nurses are in risky ethical situations, they need moral courage to act according to their core values, beliefs, or moral conscience. For nurses to act with moral courage means they choose the ethically right decision, even when under intense pressure by administrators, coworkers, and physicians. Refer to the boxes in the first few pages of this chapter to imagine ways that nurses could practice moral courage.

Over the past several years, Lachman has published several articles on the topic of moral courage. In 2010 she reviewed the nurse's obligations and moral courage in terms of do-not-resuscitate (DNR) orders for end-of-life decision making while taking into account the research by Sulmasy, He, McAuley, and Ury (2008) on beliefs and attitudes of nurses and physicians about DNR orders. Because nurses have a very close proximity to patients, they need active involvement in decision making for end-of-life decisions, such as DNR orders (Lachman,

Research Note: Nurses and Physicians on DNR Orders

Sulmasy et al. (2008) surveyed more than 500 medical house staff, medical internists, and staff nurses working on medical units at teaching hospitals in the New York City area to examine and compare (1) their beliefs, attitudes, and confidence about DNR orders; (2) the role of nurses in discussions with patients and families about DNR orders; and (3) perceived confidence level in their ability to discuss DNR orders with patients and families. As of 2008, the small number of studies on this topic revealed that nurses play an important role in discussions with patients and families regarding DNR orders, but in reality physicians are largely the ones who initiate and discuss DNR orders with patients and families. Nurses often view themselves as responsible yet powerless and uncertain about discussions with patients and families (Stenburg, 1988, as cited in Sulmasy et al., 2008). Sulmasy and colleagues' comparison findings among three groups about their roles in DNR orders indicated the following:

- Nurses found it less difficult, but more rewarding, than the two groups of physicians to discuss DNR orders with patients and families.
- Nurses reported they were not consulted very often about the evolvement of the process of end-of-life patient decisions and DNR orders.
- Nurses reported a more positive attitude about DNR discussions than did the two groups of physicians.
- Nurses were much more likely to believe it was not their place to recommend or initiate DNR orders than did the two groups of physicians.

Sulmasy and colleagues posed some ethical questions for reflection: (1) Why are staff nurses not permitted, most of the time, to initiate DNR orders? (2) What is the proper division and line of responsibilities between physicians and nurses in the care of patients during the end-of-life process? and (3) What policy on responsibilities of DNR orders would best benefit patients and families?

Source: Sulmasy. D. P., He, M. K., McAuley, R., & Ury, W. A. (2008). Beliefs and attitudes of nurses and physicians about do not resuscitate orders and who should speak to patients and families about them. *Critical Care Medicine*, *36*(6), 1817–1822.

2010). In 2012 the ANA published a new position statement to reiterate the importance of nurses' involvement in patients' end-of-life decisions and DNR orders.

Nurses often feel apprehensive regarding uncertainty in outcomes, even when they have a high degree of certainty that they are doing the right thing. Other than end-of-life decision making, other examples of having moral courage are as follows: (1) confronting or reporting a peer who is stealing and using drugs at work; (2) confronting a physician who ordered questionable treatments not within the reasonable standard of care; (3) confronting an administrator regarding unsafe practices or staffing patterns; (4) standing against peers who are planning an emotionally hurtful action toward another peer; and (5) reporting

Focus for Debate: Is Moral Courage Necessary for Nurses?

Sulmasy and colleagues (2008) raised some significant questions for ongoing reflection and interprofessional dialogue. Since the time of this study and others, the ANA recognized the need to refresh its statement on end-of-life decisions and DNR orders and, as a result, it superseded its 2003 position statement with a new position statement in 2012 on patient end-of-life decisions and DNR orders. Nurses continue to experience considerable difficulties and moral distress about patient decisions about end-of-life and DNR orders, possibly because of their own moral conflicts with the decisions or restrictions in their involvement in the decision-making process.

Is moral courage necessary? If so, how much and in what contexts and circumstances? The ANA's new position statement indicates the need for nurses to meet their ethical obligations by participating more actively in patient and family end-of-life decisions, including DNR orders, but only when those actions do not violate the principle of nonmaleficence. If nurses encounter undue moral distress or conflict over an end-of-life decision or DNR order they find questionable, they should arrange for a transfer of care to a competent nurse who is willing to engage fully in patient and family discussions and care.

Apply the same guidelines to this debate as you did for previous debates in this chapter. Before you formulate your position, refer to Sulmasy and colleagues (2008) and the ANA's new position statement (2012). Then, conduct an Internet and database search to discover other strategies and creative ways to practice moral courage.

Defend your position on the following questions:

- In what ways can nurses practice moral courage regarding patient and family discussions of end-of-life decisions and DNR orders? To answer this question, also consider the following: To what extent should the nurse be involved in initiating end-of-life decisions and DNR orders? Is it the nurse's place to recommend or not recommend a DNR order?
- Discuss some strategies and creative ideas for practicing moral courage in other circumstances.

another nurse for exploitation of a patient or family member, such as when a nurse posts a picture or a story of a patient on a social networking site.

Although a potential threat exists for physical harm, it is more likely that threats will materialize in the form of "humiliation, rejection, ridicule, unemployment, and loss of social standing" (Lachman, 2007, p. 131). Nurses can facilitate having moral courage in two ways during threatening situations. Nurses would probably regret any careless and hasty reactions, or even nonreaction or silence, on their part, so they must first try to soothe inner feelings that could trigger these behaviors. Self-talk, relaxation techniques, and moral reasoning to process 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 (Lachman, 2007).

Communication

The next ethical competency is communication. There is a long trail of research on nurse–physician, nurse–nurse, and nurse–patient relationships related to ethical and unethical communication. Refer to sections later in this chapter on nurse–physician and nurse–nurse relationships for a discussion of a few studies.

Communication means to impart or exchange information in meaningful, clearly understood ways between the communicators. Effective communication nurtures relationships and is fundamental to nursing; it therefore engages nurses to express messages clearly and understand the meaning of what is being communicated. To be effective, nurses must reside in a state of mindfulness and be an effective listener. Both of these parts of communication are integral for effective communication.

Mindfulness

Important to the ethical competency of communication is mindfulness, which in the past few decades has gained significant meaning and implications for nursing and other healthcare fields. The term *mindfulness* traces back to Eastern Buddhist philosophy as one element of the Noble Eightfold Path. When Jon Kabat-Zinn began teaching mindfulness training in 1979 at the University of Massachusetts Medical School and founded the Mindfulness-Based Stress Reduction Program, the American and other Western healthcare systems embraced the concept and expanded research-based knowledge, especially in secular practice (Center for Mindfulness, 2014; Greater Good, 2014).

Mindfulness is the degree of quality that requires "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 2009, p. 4). This definition indicates that mindful people are engaged and attentive in their activities or roles by continuously analyzing, categorizing, and distinguishing data. People with expertise and specialized skills, such as nurses, physicians, and others, need mindfulness on a minute-by-minute basis for providing safe and competent care and building good and positive relationships with patients, other nurses, and physicians.

Even with mindfulness as a critical requirement of communication in the workplace, healthcare professionals are susceptible to in-and-out moments of mindlessness, which is opposite of mindfulness. *Mindlessness* is a state of unawareness and not focusing, similar to functioning in autopilot mode. The moments of mindlessness can potentially increase in duration, and over a long period people thoughtlessly begin ruling out their full range of options in everyday life and work. People in perpetually mindless states find themselves trapped in a state of unawareness without any regard to expanding choices and views in different

contexts or cultures. Eventually they are stuck in habits of not seeing (Kabat-Zinn, 2009).

The benefits of mindfulness exercises and training are numerous, and research supports its value and therapeutic benefits. The following examples are some of the benefits:

- Reduces stress, negative emotions, and depression
- Enhances healthier living and eating and an overall sense of quality of life
- Enhances attention skills and focusing
- Enhances communication skills
- Promotes more positive relationships
- Increases memory and learning capacity
- Increases the ability for a deeper type of empathy, compassion, serenity, and altruism
- Increases the immune system's ability to fight off disease

The focus of this section is the benefits of mindfulness in communication. A body of research exists on the connection between communication and mindfulness. Mindfulness enriches the moral quality of the interactions between nurses and patients, nurses and physicians, and nurses and other nurses. Effective communication facilitates nurses' ethical behavior in work; that is, to provide ethical care to achieve better patient outcomes. Mindful nurses pay close attention to their attitudes and find ethical ways to interact and behave. When nurses intentionally focus on the present moment, the present problems and issues, and the present surroundings and interactions, all in a nonjudgmental way, they reduce their own stress and expand their vision of care to a wider choice of options to effect improved patient outcomes.

Mindfulness exercises promote nurses' ability to focus and stay alert to the details of decision making and patient care. In a booklet published by the ANA, titled *Mindfulness and You: Being Present in Nursing Practice*, Bazarko (2014) emphasized the need for nurses to practice mindfulness, take care of themselves, and thus provide safe patient care. In the booklet are examples of mind–body therapies, strategies for improving the mind–body connection, and a guide for a mindfulness journey.

Formal meditation is one primary way to cultivate mindfulness. However, in a video called *The Stars of Our Own Movie* (Greater Good, 2010), Kabat-Zinn emphasized that mindfulness is not just about sitting in the lotus position; it is more about living life as if life is genuinely worth living, moment by moment.

Some ways to begin brief daily mindfulness exercises are as follows (Greater Good, 2014):

- Pay close attention to your breathing, especially when you're feeling intense emotions.

Ethical Reflection: Kabat-Zinn's View of Being Truly in Touch

> To allow ourselves to be truly in touch with where we already are, no matter where that is, we have got to pause in our experience long enough to let the present moment sink in; long enough to actually feel the present moment, to see it in its fullness, to hold it in awareness and thereby come to know and understand it better. Only then, can we accept the truth of this moment of our life, learn from it, and move on. (Kabat-Zinn, 2009, Introduction)

Source: Kabat-Zinn, J. (2005). Introduction. Wherever you go, there you are: Mindfulness meditation in everyday life. New York: Hyperion, pp. xiii–xiv. Reprinted by permission.

- Notice—really notice—what you're sensing in a given moment, the sights, sounds, and smells that ordinarily slip by without reaching your conscious awareness.
- Recognize that your thoughts and emotions are fleeting and do not define you, an insight that can free you from negative thought patterns.
- Tune in to your body's physical sensations, from the water hitting your skin in the shower to the way your body rests in your office chair (para. 2).

Effective Listening

Effective listening is the other essential feature of the ethical competency of communication. A state of mindfulness must be present for a person to effectively listen. Without attention and a strong focus, listeners cannot respond appropriately no matter how well meaning a person's intention of listening is. As previously mentioned, people often experience in-and-out awareness moments as distractions, and wandering-off moments trickle through the mind.

Effective listening means the communicators in the exchange will comprehend the active information, then they form a mutual understanding of the essence of the dialogue (Johnson, 2012). The mutual understanding compels the listeners to repeat the message to clarify facts and other details. When nurses earnestly listen, they do so with extreme thinking power because they must show a nonjudgmental interest in what the speaker is saying, absorb the information, and provide nonverbal cues and verbal feedback to signal an understanding of the message to the speaker. Why is effective listening so important to nurses? The foremost reason is that nurses have a moral obligation to provide competent care and build positive work relationships to promote better patient outcomes. Nurses will not give competent care if their minds are wandering. They risk misinterpreting facts, physician's orders, or patient interactions.

Concern

Concern is the last major ethical competency. The competency of *concern* means that nurses feel a sense of responsibility to think about the scope of care important

for their patients; sometimes a sense of worrying about the health or illness of patients prompts nurses to action. Being an advocate, using power, and giving culturally sensitive care compose the ethical competency of concern for patients.

Advocacy

A general definition of *advocacy* is pleading in favor of or supporting a case, person, group, or cause, but many variations on the definition of advocacy exist. Related to professional nursing ethics, Bu and Jezewski (2006) found three central characteristics of *patient advocacy* in their concept analysis:

- Safeguarding patients' autonomy
- Acting on behalf of patients
- Championing social justice in the provision of health care (p. 104)

Patient advocacy, an essential element of ethical nursing practice, requires nurses to embrace the promotion of well-being and uphold the rights and interests of their patients (Vaartio, Leino-Kilpi, Salanterä, & Suominen, 2006). The ANA (2015) did not explicitly define the terms *advocacy* or *patient advocacy* in the *Code of Ethics for Nurses with Interpretive Statements*, although advocating for the patient is an expectation, as evidenced by Provision 3 of the code: "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient" (ANA, 2015, p. 9).

Nurses are to be advocates for patients and their rights; for public and community social justice areas of health care, policy, and economics; and for each

Ethical Reflection: Examples of Nursing Advocacy Obligations

The following are examples of nursing advocacy obligations in the ANA *Code of Ethics for Nurses with Interpretive Statements*:

1. The nurse advocates for an environment that provides sufficient physical privacy... (Provision 3.1, p. 9).
2. Nurses have a duty …to advocate for participants who wish to decline to participate or to withdraw from a study before completion (Provision 3.2, p. 11).
3. …[N]urses…must advocate for appropriate assistance, treatment, and access to fair institutional and legal processes (Provision 3.6, p. 13).
4. [Nurses] must also participate as advocates or as elected or appointed representatives in civic activities… (Provision 7.3, p. 28).
5. Nursing must also advocate for policies, programs, and practices within the healthcare environment…. (Provision 9.4, p. 37).

Source: Excerpts quoted from American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author, Provision 3.

Ethical Reflection: Barriers to Nursing Advocacy

Hanks (2007) identified barriers to nursing advocacy based on findings from existing literature:

- Conflicts of interest between the nurse's moral obligation to the patient and the nurse's sense of duty to the institution
- Institutional constraints
- Lack of education and time
- Threats of punishment
- Gender-specific, historical, critical social barrier related to nurses' expectations of a subservient duty to medical doctors

Source: Hanks, R. G. (2007). Barriers to nursing advocacy: A concept analysis. *Nursing Forum, 42*(4), 171–177.

other. In matters of patient care, nurses are in ideal positions for patient advocacy. Nurses can clarify and discuss with patients their rights, health goals, treatment issues, and potential outcomes, but they must realize some of the barriers to advocacy. These barriers arise as shadows from unresolved issues.

Hamric (2000) offered excellent ways for nurses to boost their patient advocacy skills: (1) nursing educators need to convert basic ethics education to real-life application and action; (2) practicing nurses need to continue their education on the ethical imperatives of advocacy; and (3) institutions need to review their incentives, if any, to promote patient advocacy. Butts (2011) created an acronym, PRISMS, as a reminder of strategies to promote patient advocacy.

Ethical Reflection: PRISMS

PRISMS is an acronym for key action verbs that describe strategies to promote patient advocacy:

P: Persuade
R: Respect
I: Intercede
S: Safeguard
M: Monitor
S: Support

Source: Butts, J. B. (2011). PRISMS—An Acronym for key action verbs for strategies to promote patient advocacy. Personal Collection. Ellisville, MS, copyright 2011.

Power

Power, by definition, means a person or group has influence in an effective way over others—power results in action. Nurses with power have the ability to influence persons, groups, or communities. Nurses who are ingrained with the ideals of *socialized power* seek goals to benefit others with intent to avoid harm or negative effects—an indication of the principles of beneficence, nonmaleficence, and justice at work. Goals of social benefit to others are accomplished often through global and national efforts, or efforts of members of large service or state organizations. Individual volunteer organizational work by nurses contributes toward efforts of shared goals within larger organizations and smaller shared goals for individuals and communities.

Nurses and patients together form a powerful entity because of evolving paradigm shifts in clinical, political, and organizational power (Hakesley-Brown & Malone, 2007). In the past nurses facilitated patients' emancipation from a paternalistic form of care to today's autonomous decision makers seeking quality care. Because nurses participate in and direct activities involving patient care, they are in powerful positions to improve quality in patient care and oversee professional nursing practice standards. Nurses continue to take advantage of their empowerment as a profession to control the content of their practice, the context of their practice, and their competence in practice.

Ponte and colleagues (2007) interviewed nursing leaders from six organizations to understand the concept of power from the leaders' perspectives on ways nurses can acquire power and ways leaders demonstrate power in practice and in work. According to the leader participants in the study, power lies within *each nurse* who engages in patient care and in other roles, such as in organizations, with colleagues, and within the nursing profession as a whole. As nurses develop knowledge and expertise in practice from multiple domains, they 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). Eight properties of a powerful professional practice can serve as a foundation for current and future power in nursing.

Culturally Sensitive Care

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 is a core element in closing the gap on health disparities. *Culturally sensitive care* means nurses must first have a basic knowledge of culturally diverse customs and then demonstrate constructive

Research Note: Properties of a Powerful Professional Nursing Practice

Nurses who have developed a powerful nursing practice do the following:

- 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 oneself] 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.

Source: Quoted from Ponte, P. R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrell, R.,… Washington, D. (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). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/tpc32_316092.aspx

Ethical Reflection: Two Levels of Power

There are a variety of ways in which power is abusive, coercive, or not used at all. In fact, nurses who do not use their power for the good of a situation are ineffective. The following two examples of power represent one on a smaller scale and one on a larger scale.

Power on a Smaller Scale

Ms. Gomez's liver cancer is inoperable and incurable. She is unaware of her diagnosis and prognosis, but she realizes she is experiencing abdominal pain that she described as level 8 on a 10-point scale. Everyone working in the oncology unit is involved in her care and is aware of her diagnosis. For a few days the nurses had been observing Ms. Gomez's continued edginess and irritability as they interact with her. Ms. Gomez senses something is terribly wrong and begins to panic when physicians gather in her room during clinical rounds and talk medical jargon about her "case" in front of her. Ms. Gomez experienced an acute anxiety reaction. The outcome of this situation could have been better managed if her nurse had discussed the situation with the physicians beforehand and tried to convince them to discuss her case somewhere else, or the nurse could have politely asked them to explain Mrs. Gomez's diagnosis and prognosis to her. Had the nurse exerted a noncoercive power over this situation, the outcome would have been averted.

(*continues*)

Ethical Reflection: Two Levels of Power (continued)

Identify some specific strategies the nurse can use to establish, on a small-scale or unit level, policies about clinical rounds or disclosure to patients?

Power on a Larger Scale

Nurse Mary works at a hospice located in a coastal region and has six patients in her care. The national weather center forecasted several potential life-threatening hurricanes for her region during the next few weeks. Most of her patients are financially challenged. Mary 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 a disaster; or (3) she could educate her patients and families on disaster preparedness and use her power to help poor, homebound patients—not just her patients—in the community to prepare for the disaster. One way for Mary to exercise her power immediately on a large, community-wide scale is to have an immediate fundraiser and supply drive, then work with agencies such as the American Red Cross to recruit community or nurse volunteers for distributing the supplies, handing out disaster preparedness information, and verbally educating the families.

What other strategies could Mary implement?

attitudes based on learned knowledge (Spector, 2012). A culturally competent nurse or healthcare provider

> develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided. Cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear. (Purnell, 2002, p. 193)

The process of nurses getting to know themselves and their values, beliefs, and moral compass is fundamental to providing culturally competent care (Purnell, 2011). Without some degree of cultural knowledge, nurses cannot possibly provide ethical care; for example, relationships with others cannot develop into a trusting, respectful exchange.

Lipson and Dibble's (2005) trademarked acronym, ASK (awareness, sensitivity, and knowledge), can be used by nurses to approach patients from various cultures. The many cultures in the United States differ in their beliefs about health, illness, pain, suffering, birth, parenting, death, dying, health care, communication, and truth, among others. Nurses need to conduct a quick assessment of cultural diversity needs (Lipson & Dibble, 2005). The following cultural assessment is an easy and quick approach based on ASK:

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? (Lipson & Dibble, 2005, p. xiii)

Nurses' genuine attention to cultural diversity and the diversity within each culture promotes ethically competent care, which is essential in everyday nursing practice. In addition, nurses must increase their knowledge when caring for culturally diverse patients. Provision 1 of the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015) compels nurses to care for persons regardless of social or economic status, personal attributes, or nature of health problems. If nurses uphold Provision 1, they plausibly will provide cultural sensitive care.

In this section you have read about selected nursing ethical competencies: (1) moral integrity—honesty, truthtelling, benevolence, wisdom, and moral courage; (2) communication—mindfulness and effective listening; and (3) concern—advocacy, power, and culturally sensitive care. Refer to the following boxes to test your moral grounding.

Ethical Reflection: Ethical Competencies of Nurses—Test Your Moral Grounding!

Thus far you have learned about the ethical competencies that define an ideal nurse. The codes of ethics and the ethical competencies serve as a foundation for nurses to develop moral grounding for professional practice, education, research, and leadership.

Test your personal moral grounding! List the ethical competencies of a nurse and write down how these competencies will relate to your ethical nursing practice. Briefly imagine or discuss an ethical situation that could arise with regard to each competency, then give a corresponding resolution.

Moral integrity:

- Honesty
- Truthfulness and truthtelling
- Benevolence
- Wisdom
- Moral courage

Communication:

- Mindfulness
- Effective listening

Concern:

- Advocacy
- Power
- Culturally sensitive care

Focus for Debate: Ethical Competencies—Test Your Moral Grounding! Is It OK for a Student to Cheat?

Gilda, a nursing student, discovered a website that provides fee-for-service tests with answers and rationales, based on test banks from older editions of books. The legality and ethicality of the company's business are questionable, but Gilda has an upcoming exam in her health assessment class and does not have time to study because of family issues. The company's website advertises test customization for any subject matter. Without much forethought, Gilda ordered a customized test, and the company sent her digital access to it. Gilda studied the questions and answers. While she took the actual course exam, however, she realized that some of the questions were either very different or had variations of the wording in the purchased test, but a few questions were similar. She was happy to see a score of 82 on her course exam.

Explore the following questions to test your moral grounding. Consider a live or online classroom debate for this exercise with two or more groups of students.

- Before you continue with this activity, analyze your moral grounding. Write down basic morals you value in your personal life and what you will or currently value as a nursing professional. Where do you stand?
- Is Gilda's action considered cheating or academically dishonest by your college or university standards? Why or why not? Please explain.
- When you violate the academic integrity policy of your college or university, what can happen if you are caught? Please explain your rationale.
- Do you believe Gilda considered the action to be a necessary means to a necessary end? When answering, explore all options and consequences from the perspective of utilitarian theory.

(The story continues.)

Gilda discovered another nursing student who had difficulty passing tests. She approached the student and explained about finding the company that sells tests, but the student had uncomfortable feelings about ordering a test. The student discussed the issue with a couple of her friends from nursing school to seek their guidance. Those students told the professor about Gilda's action and the test company. Gilda was caught by such surprise when the professor approached her to verify the story that she was too nervous not to admit her actions. She rationalized it by explaining her lack of time and the family issues, then she pleaded with the professor to overlook this one incident and said she would never cheat again. Based on the academic integrity policy, however, Gilda failed her course and was dismissed from the program.

- What was an alternative action for Gilda? Derive your explanation from any of the ethical theories or approaches, such as utilitarian theory, Kant's deontology framework, or a virtue ethics approach.
- What are a couple of academically dishonest scenarios? How do these examples compare to Gilda's action?

Nursing Professional Relationships

Nurse–Physician Relationships

In centuries past and even today, women have experienced oppression related to inequity issues and hierarchical relationships, such as in political structures and doctrines and in certain religious orders. History reveals a significant degree of

women's oppression. From the 1300s to the 1600s women who claimed to be healers were burned at the stake after accusations of witchery (Ehrenreich & English, 1973). Other events also gave rise to oppression of women during that same time. By the early 20th century, Florence Nightingale's work in the 1800s helped move nurses to a more respected, notable standing, but some people continued to think of women in general as functioning only in domestic roles. Nurses, to varying degrees, have been working since then to overcome this perception.

Stein (1967), a physician, identified a type of relationship between physicians and nurses that he called the *doctor–nurse game*. The game originated from a hierarchical relationship, with doctors being in the superior position. The hallmark of the game is the avoidance of open disagreement between the disciplines. Avoidance of conflict is achieved when an experienced nurse cautiously offers suggestions in such a way to keep the physician from perceiving that consultative advice is coming from a nurse. In the past student nurses were educated about the rules of the game while attending nursing school. Over the years others have acknowledged the historical accuracy of Stein's characterization of doctor–nurse relationships (Fry & Johnstone, 2002; Jameton, 1984; Kelly, 2000).

Stein, Watts, and Howell (1990) revisited the doctor–nurse game concept 23 years after Stein first coined the phrase. Nurses unilaterally had decided to stop playing the game. Some of the reasons for this change and the ways change was accomplished involved nurses' engaging in more dialogue rather than gamesmanship, the profession's goal of equal partnership status with other healthcare professionals, the alignment of nurses with the civil rights and women's movements, the increased percentage of nurses who achieved higher education, and collaboration between nurses and physicians on projects. In the process of abandoning the game, many nurses took a less than a togetherness approach toward physicians.

Some nurses believe an adversarial fight needs to continue to establish nursing as an autonomous profession. Nurses' reports and opinions of strained relationships between nurses and physicians have steadily appeared in the literature in many countries, despite efforts by some nurses to have friendlier relationships with physicians. Reported reasons for the strained relationships include the following: (1) the hierarchical way ethical care decisions are made—both institutional system decisions and physician decisions; (2) competency and quality-of-care conflicts; and (3) lack of communication.

Other researchers echoed Malloy and colleagues' (2009) findings of nurses' perceptions of inequality with physicians. Churchman and Doherty (2010) found that solutions to address inequality with physicians are complex and do not exist universally because certain factors contribute to the challenge of finding answers: (1) nurses are discouraged from confronting physicians in everyday practice, (2) they fear conflict and aggression by physicians, and (3) they fear having their

Research Note: Qualitative Focus Group Study on an Organizational Culture

Forty-two nurses from a variety of settings in four nations (Canada, Ireland, Australia, and South Korea) participated in Malloy and colleagues' (2009) qualitative focus group study to express their opinions on dilemmas and decisions in the everyday care of elders with dementia, as well as to identify how end-of-life decisions are made. The researchers extracted four themes in conjunction with an *unexpected* finding that nurses from all countries consistently voiced strained and powerless hierarchical relationships with some physicians:

- The first theme arose because of two different philosophies; care (nurses) versus treatment (physicians) was a source of tension between nurses and physicians on end-of-life decisions.
- The second theme was a constrained obligation in terms of the nurse–physician hierarchy, established protocol, and the way decisions were made.
- Third, nurses perceived physicians, patients, families, and the system as silencing the nurse's voice; they also believed themselves to be unequal participants in the care of patients, largely because of the system.
- The fourth theme was a lack of respect for the profession of nursing from other professionals.

Source: Malloy, D. C., Hadjistavropoulos, T., McCarthy, E. F., Evans, R. J., Zakus, D. H., Park, I., . . . Williams, J. (2009). Culture and organizational climate: Nurses' insights into their relationship with physicians. *Nursing Ethics*, *16*(6), 719–733.

views disregarded. Institutional hierarchy continues to be a source for unequal rewards and power between nurses and physicians.

Nurse–Nurse Relationships

In the provisions of its *Code of Ethics for Nurses with Interpretive Statements*, the ANA (2015) characterized various ways nurses demonstrate their primary responsibility to their patients, families, and communities. Some key indicators in the code illustrate this responsibility, such as having compassion for patients, showing respect to patients and to each other, collaborating with other healthcare professionals, protecting the rights and safety of patients, advocating for patients and their families, and caring for and preserving the integrity of oneself and others. Patient and family relationships are important, but good relationships with other nurses and with other healthcare professionals are necessary for the successful follow-through of the responsibility to patients.

Nurses often treat other nurses in hurtful ways through what some people have called lateral or horizontal violence (Christie & Jones, 2013; Kelly, 2000; McKenna, Smith, Poole, & Coverdale, 2003; Thomas, 2009). *Horizontal*

Research Note: Qualitative Study of the Interprofessional Nurse–Physician Relationship

Pullon's (2008) qualitative study of 18 nurses and physicians in primary care settings from New Zealand is an example of research on features that build an interprofessional nurse–physician relationship. Pullon identified certain extrinsic and intrinsic factors of this relationship, but the article is focused only on the intrinsic nature of individual interprofessional relationships. Demonstrated professional competence, which is a key feature of interprofessional relationships, served as the foundation of respect for each other and, in turn, formed a level of trust calculated over time with reliable and consistent behavior. The findings were as follows:

- Nurses and physicians identified their professional groups as distinct but complementary.
- Nurses described the formation and maintenance of quality professional relationships with patients and others as the heart of their professional work, and they described teamwork as one means for achieving those relationships.
- Physicians depicted the physician–patient relationship as the crux of their practice, but only in the context of consultation.
- Nurses and physicians both unveiled several shared values and attitudes: (1) the provision of continuity of care; (2) the ability to cope with unpredictable and demanding care; (3) the importance of working together and building a relationship; and (4) the significance of professional competence, mutual respect for each other, and trust in an ongoing relationship, but with the realization that trust could be broken quickly in the early stages of a trustworthy relationship.

Source: Pullon, S. (2008). Competence, respect, and trust: Key features of successful interprofessional nurse-doctor relationships. *Journal of Interprofessional Care, 22*(2), 133–147.

violence, also known as *workplace bullying*, involves interpersonal conflict, harassment, intimidation, harsh criticism, sabotage, and abuse among nurses. It may occur because nurses feel oppressed by other dominant groups, such as physicians or institutional administrators; subsequently, nurses turn their anger toward each other.

Acts of horizontal violence often occur subtly. The behaviors repeat and escalate over a long period of time. Some nurses characterize violence that is perpetrated by nurses against other nurses who excel and succeed as the *tall poppy syndrome* (Kelly, 2000). The perpetrators feel they need an outlet for their pent-up anger, so they cut down the tall poppies (nurses) who outshine them. This type of behavior creates an ostracizing nursing culture that discourages individual success and recognition. The term *tall poppy syndrome* was popularized in Australia and New Zealand, where is used as a derogatory reference, but the concept originates from Greek and Roman philosophers and writers.

Thomas studied the causes and consequences of nurses' stress and anger. Nurses voiced horizontal and vertical violence as common sources of stress. "One of the most disturbing aspects of our research data on nurses' anger is the vehemence of their anger at each other" (Thomas, 2009, p. 98). The findings indicated the following common characteristics of horizontal violence:

- Subtle nonverbal behaviors, such as rolling eyes, raising eyebrows, or giving a cold shoulder
- Sarcasm, snide remarks, rudeness
- Undermining or sabotaging
- Withholding needed information or assistance
- Passive-aggressive (behind the back) actions
- Spreading rumors and destructive gossip
- False accusations, scapegoating, blaming (p. 98)

Horizontal Violence and Wounded Healers

Horizontal violence, or workplace bullying, in nursing is counterproductive for the profession. Nurses experience a significant level of horizontal violence, sometimes more so than in other helping professions. These long-term emotional effects can compromise patient safety and the nurses' ability to practice proficiently (Thomas, 2009). If stress and traumatic feelings are not managed properly, the unrecognized and unmanaged effects lead to unproductive coping and unresolved issues; traumatized nurses will function as the *walking wounded* (Christie & Jones, 2013). Soon others will observe that the walking wounded have difficulty in professional and personal relationships with other people.

Healing can occur. The first step in healing is recognizing the effects of the trauma. Deep self-awareness is necessary for grasping some personal meaning (Conti-O'Hare, 2002). This awareness enables wounded nurses to initiate work toward improving their coping mechanisms. Only then can nurses begin transforming and transcending their wounds toward healing, thus becoming wounded healers.

Wounded healers are informed by their own traumatic and difficult experiences that occur in the process of their everyday work, but they also transform their raw wounds to a healed scar that enables a better understanding of others' pain. In essence, a wounded healer has a rich sense of empathy for others because of past personal wounds (Groesbeck, 1975). The process of healing takes time and requires a strong desire to develop as a wounded healer. "Woundedness lies on a continuum, and the wounded healer paradigm focuses not on the degree of woundedness but on the ability to draw on woundedness in the service of healing" (Zerubavel & Wright, 2012, p. 482).

Improving Nurse–Nurse Relationships

Safeguarding patients and patient care is a moral priority, and positive nurse–nurse relationships promote the moral climate necessary for safe and competent care. Sometimes nurses or nursing leaders must take unpleasant, but not spiteful, action with regard to nursing behaviors and the protection of patients. Nurses serve as advocates when they take appropriate action to protect patients from unethical, illegal, incompetent, or impaired behaviors of other nurses (ANA, 2015). For nurses who become aware of these behaviors, appropriate actions involve reviewing policies, seeking guidance from administrators in the chain of command, documenting the occurrences, and approaching the offending nurse in a constructive, compassionate manner. Gossip, condescension, or unproductive derogatory talk are negative tactics that do not help and serve only to damage reputations and relationships.

Nurses can strengthen a sense of community within the profession by working to heal the disharmony and transform their anger to support other nurses' accomplishments rather than treating them as tall poppies that must be cut down. Individual nurses need to self-reflect at the end of the work day by examining their actions and the dialogue they had with others. All nurses—those who follow through with daily self-reflection and those who do not—need to "make a commitment to supportive colleagueship" and "refuse to get caught up in workplace negativism" (Thomas, 2009, p. 109).

Nurses and Social Media

Many people who use the Internet have already experienced, to some degree, the consequences of unethical or illegal behavior, such as being the target of someone else's devious actions. The digital age has brought about new levels of public exploitation to many people. Computers strongly influence our personal and professional lives every day. Because of this influence, nurses and nursing students need to understand the potential for unethical and illegal behaviors.

Moral Spaces and Blurred Lines

The risk for crossing professional boundaries increases as lines and moral spaces become blurred in nursing practice. Blurred-lined behaviors and obvious line crossings involve an invasion of the moral spaces of others and possibly a violation of their privacy. What nurses could view as a flippant or innocent social media comment may be perceived by others as vulgar, inflammatory, or threatening. Whether the nurse remarked as a joke or as an intentional display of hostility, the comment can quickly transform from mere opinion to fact-based information.

Moral space is defined as "what we live in . . . any space formed from the relationships between natural and social objects, agents and events that protect or establish either the conditions for, or the realization of, some vision of the good life, or the good, in life" (Turnbull, 2003, p. 4). Respect for one another's moral spaces takes a serious commitment by those who use the Internet. Dozens of ethical codes of conduct exist for users of the Internet, but no matter how many codes exist or what populations they serve, the codes are of no use if they are not practiced consistently or if people lack moral integrity. Nurses and nursing students must remain devoted to respecting human beings in all interactions and actions, including all features of social networking. Violations of the principle of autonomy generally involve matters of respect for human beings, self-determination, trustworthiness, confidentiality, and privacy. Violations of the principle of nonmaleficence in social media exchanges include intentional and hurtful remarks that could result in perceived or actual harm to the recipients.

Social Media, Email, and Cell Phones

Social media includes Internet-based applications that enable collaborative community-based exchanges of user-generated information (Kaplan & Haenlein, 2010). Nurses routinely use social media to befriend others who have common interests or to keep in touch with friends. Facebook, Twitter, Instagram, Google+, YouTube, and other social media sites, along with email and cell phones, are essential communication tools for healthcare professionals, just as they are for others. Their usefulness has both benefits and perils.

Benefits of Using Social Media

For nurses, the positive side of social media is it provides minute-to-minute information and allows nurses to share knowledge and build professional relationships. Social networks "provide unparalleled opportunities for rapid knowledge exchange and dissemination among many people" (ANA, 2011, p. 3).

In 2011 several key nursing and physician professional organizations published statements or booklets about the use of social media. The American Nurses Association published a booklet titled *ANA's Principles of Social Networking and the Nurse: Guidance for the Registered Nurse* (2011). Three ANA documents provided a foundation for the development of the social networking principles: (1) *Code of Ethics for Nurses with Interpretive Statements* (2015), (2) *Nursing: Scope and Standards of Practice* (2010a), and (3) *Nursing's Social Policy Statement: The Essence of the Profession* (2010b Edition). The NCSBN also published a booklet titled *A Nurse's Guide to the Use of Social Media* (2011b).

Physicians also see value in the use of social networks for taking care of routine work, such as refilling prescriptions, answering questions, and sharing informational websites. In 2011 the AMA issued an opinion that echoes support

for the use of social media to allow "personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, [and] provide opportunity to widely disseminate public health messages" (2011, para. 1).

Perils of Using Social Media

Refer to the previous section titled "Moral Spaces and Blurred Lines" for a discussion of nurses who post comments on social media sites. It illustrates how just one message can have long-standing negative effects. One of the foremost perils of using social media is the risk for violation of patient privacy and confidentiality. In fact, posting *any* work-related information is a legal and ethical violation of privacy, including the identification of and providing information about patients, employers, administrators, coworkers, and others. In situations involving patients, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) (Centers for Medicaid and Medicare Services [CMS], 1996) gives patients legal privacy protection. The *Code of Ethics for Nurses with Interpretive Statements*, Provision 3.1, illustrates the ethical aspect of privacy.

Employers and other leaders sometimes label the behavior as unprofessional or illegal and also as complicated and uncertain. The growing number of employee violations is pushing employers to reinforce old policies and enforce new ones by initiating disciplinary courses of action against personnel who engage in inappropriate behaviors on social network sites and cell phones. If nurses and other healthcare professionals follow their codes of ethics and current hospital policies, new policies on social networking and cell phone use would not be necessary. Today most employers, educational institutions, and professional organizations have initiated a position or policy on the use of social media because employees are increasingly using it to complain about employers, coworkers, or even patients and families.

Legal Perspective: HIPAA, the Privacy Rule, and Protected Health Information

The Privacy Rule in HIPAA legally protects patient health information in any form, whether electronic, paper, or oral (CMS, 1996; U.S. Department of Health and Human Services, 2003). The public nature of any social or electronic communication poses ethical and legal problems, such as violations of the HIPAA Privacy Rule. Issues arise when nurses, physicians, and patients share information that identifies the person's past, present, or future physical or mental condition; the type of health care received or considered; or past, present, or future payment for healthcare services.

Source: Adapted from U. S. Department of Health and Human Services. Office of Civil Rights. (2003, May). Summary of the OCR privacy rule. Washington, DC: Author. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Ethical Reflection: Privacy and Confidentiality in the ANA *Code of Ethics for Nurses*

> Privacy is the right to control access to, and disclosure or nondisclosure of, information pertaining to oneself and to control the circumstances, timing, and extent to which information may be disclosed. Nurses safeguard the right to privacy for individuals, families, and communities…. Confidentiality pertains to the nondisclosure of personal information that has been communicated within the nurse-patient relationship. (ANA, 2015, p. 9)

Source: Quoted from American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author, Provision 3.1.

Actual Cases of Violations

The potential exists for many violations in social media, email, and cell phones, both in nurses' everyday work and in their personal lives. The following real-life case has been published in many articles and was a nationally publicized incident (NCSBN, 2011d).

In two other alarming stories, nurses were suspected of patient exploitation and violations of confidentiality and privacy. One incident occurred in 2010 at Tri-City Medical Center in Oceanside, California. The medical center fired five nurses and disciplined a sixth nurse for violating confidentiality. According to a spokesperson at the medical center, there was enough substantial information to warrant the firings of the five nurses because they had discussed patient cases on Facebook ("Five Nurses Fired," 2010).

In the other social media case, the Louisiana State Board of Nursing filed complaints against three nurses at the St. Tammany Parish Hospital emergency room after discovering abhorrent patient mistreatment. Lee Zurik (2012), an investigator for Fox 8 Live WVUE-TV, reported the story. Reba Campbell, an emergency room technician, reported nurses for allegedly exploiting, making fun of, and taking cell phone pictures of unconscious patients on at least two different occasions. One case involved an overweight man who overdosed on pain and anxiety medications. According to Zurik (2012), Campbell stated the following:

> Clancy [one of the three reported nurses] the other nurse walks in and puts these glasses on the patient and starts to make fun of him. That wasn't funny enough, so they took charcoal that we dumped down his throat and painted his face like a football player and said, "Welcome to St. Tammany Parish Hospital ER. This is your initiation for trying to kill yourself." (Zurik, para. 5)

Ethical Reflection: A Case of Email Forwarding

Sally, a nurse employed at a large long-term care facility, arrived at work to find a strange email from the previous night shift on her laptop. The source was unknown. Attached to the email was a photo of an elderly female wearing a gown, bending over, with an exposed backside. Sally asked the other day shift staff members about the email and photo, and some confirmed they had received it on their office computers. No one knew anything about the source of the email or the identity of the woman in the photo, although the background appeared to be a patient room at the facility. In an effort to find out whether any of the staff knew who sent the email, Sally forwarded it to the computers and cell phones of several staff members, who later stated they had not seen the previous email. Some staff members were concerned, but others found it amusing and were laughing about it. Someone initiated a betting pool to guess the identity of the patient. At least one staff person posted the photo on her blog. By midday the director of nursing had become aware of the photo and began an investigation because the organization was very concerned about the patient's rights. The local media also became aware of the matter, and law enforcement was called to investigate whether any crimes involving sexual exploitation had been committed. After a large amount of media coverage and the identification of a few people engaged in the behavior, the administrator placed several staff members on administrative leave and reported the incident to the state board of nursing. The board investigated the reported nurses to determine if federal regulations pertaining to exploitation of vulnerable adults were violated. No one ever discovered the originator of the email and photo. After administrators identified the patient, her family threatened to sue the facility and all the involved staff. When the NCSBN white paper to guide nurses on the use of social media was published (2011d), the board of nursing complaint was pending.

This scenario reflects the importance for nurses to consider their actions carefully. The nurses had a duty to immediately report the incident to their supervisor to protect patient privacy and maintain professionalism. Instead, the situation escalated to involve the board of nursing, the prosecutor, and the national media. The family experienced a high degree of humiliation, and the organization faced possible legal consequences and embarrassment by the national media focus.

Source: Data from National Council of State Boards of Nursing (NCSBN). (2011). *White paper: A nurse's guide to the use of social media*. Chicago, IL: Author. Retrieved from https://www.ncsbn.org/Social_Media.pdf

Then two other nurses pulled out their cell phones for photos. Campbell stated that the nurses took pictures of the patient, who was unconscious (Zurik, 2012). The nurses had evidently taken pictures in the past of unconscious patients because the coworkers had been observed sitting at a desk giggling and ranking which pictures of different patients rated the highest. One of the nurses even texted the photos from her cell phone to a physician who chose a patient picture as the best one in a text reply to the nurse. The attorney representing the unconscious patient named the hospital and three nurses in a lawsuit.

Not related to and before these incidents, Thomas (2009) interviewed nurses across the United States to find meaning in their layers of stress and anger over unethical, harmful, and dehumanizing treatment of patients as part of a larger study to uncover reasons for nurses' stress and anger. One of the themes discovered was "I feel morally sick." Nurses described mistreatment and disregard of patients. They found the real-life observations repugnant; they felt physically sick, disgusted, and nauseated, and they believed they were powerless to do anything about those abhorrent situations. Thomas's interpretation of the narratives was that the nurses were experiencing a significant amount of moral distress and the effects of moral residue because of their layers of stress and anger. Refer to the previous moral distress and walking wounded discussions in this chapter.

The nurses' narratives in Thomas's study were depictions of their real-life experiences and feelings about stories that were not necessarily related to social networking. Unethical and illegal events have always been described and exposed by concerned healthcare personnel, but the digital age has brought new levels of public exploitation to many patients and families. Sadly, social networking potentially could be a means for nurses to express frustrations about their workplace, coworkers, and patients and their families, but no matter what reasons exist for sharing and divulging information, nurses who do so violate professional boundaries and most likely will be fired or disciplined and will have their license suspended or revoked. Sharing any privileged information amounts to illegal, inappropriate, and unethical violations. Many nurses and physicians are seeing these concerns as a valid worry and are taking action collectively through professional organizations and healthcare organizations.

Strategies for Using Social Media

Using social media in an appropriate manner is generally not harmful and without malicious intent. Adopting an attitude to keep it appropriate will serve as a reminder to be mindful of ethical and legal implications of social media wrongdoing and a commitment to the code. Refer to this chapter's section on the ethical competency of mindfulness. Mindfulness in communication means having a keen awareness of the present moment and its surroundings, including the facts, interactions, activities, and processing of information, which suggests that mindfulness is a key element to suitable social media communication.

The American Nurses Association (2011) published six principles of social networking for nurses. Where patients, nurses, and all surrounding issues are concerned in health care, the commitments of privacy and confidentiality serve as the foundation for these six principles of social networking.

Internet-based applications changed the way people categorize, process, organize, and store information. In most of the codes of ethics for nurses, including

Ethical Reflection: ANA Six Social Networking Principles

1. Nurses must not transmit or place online individually identifiable patient information.
2. Nurses who interact with patients on social media must observe ethically prescribed patient–nurse professional boundaries.
3. Nurses should evaluate all their postings with the understanding that a patient, colleague, educational institution, or employer could potentially view those postings.
4. Nurses should take advantage of privacy settings on many social networking sites and separate their personal and professional information.
5. Nurses are obligated to question incompetent, unethical, illegal, or impaired practice and to take appropriate actions in the delivery of health care at individual or systems levels.
6. Nurses are encouraged to participate in the development of policies and procedures in their institutions and organizations for handling reports of online conduct that may raise legal concerns or are professionally unethical.

Source: Excerpts quoted and some adapted or condensed from American Nurses Association. (2011). *ANA's principles for social networking and the nurse: Guidance for registered nurses*. Silver Spring, MD: Author.

the ANA code, there are explicit discussions about nurses maintaining respect, confidentiality, and privacy; those same concepts are applicable to social networking, emailing, and cell phone use. Social media and other electronic media can be instrumental in building relationships and sharing worthwhile information, but nurses must follow the ethical guidelines within the codes of ethics and the legal regulations in the applicable states and countries.

Nurses and physicians are role models for other healthcare professionals, whether or not they want this role. Nurse role models are present in every area of nursing, including practice, education, research, and administration. Nursing newcomers emulate the conduct of the role models, both the positive and negative behaviors. It is imperative that existing nurses influence new nurses and other personnel in a positive manner.

Key Points

- Nursing ethics is defined as the examination of all kinds of ethical and bioethical issues from the perspectives of nursing theory and practice.
- Nursing as praxis means that nurses make morally good decisions with indistinguishable means and ends to follow through with those

Key Points (continued)

decisions. The central point is to maintain an ethical practice.

- To practice nursing ethically, nurses must be sensitive enough to recognize when they are facing seemingly obscure ethical issues.
- Administrators, physicians, or patients may occasionally request that nurses carry out actions that seem morally undesirable. Making a nursing decision whether to carry out this action will require further scrutiny, such as using the stench test.
- The ANA outlined nine moral provisions with nonnegotiable obligations for nurses. Detailed guidelines with interpretive statements of each provision accompany the nine provisions.
- A clear patient focus in the code obliges nurses to remain attentive and loyal to all patients in their care and also to be watchful for ethical issues and conflicts of issues that could lead to potential negative effects.
- Common themes between the ANA and ICN codes include provision of compassionate care and alleviation of suffering, with an endorsement of the bioethical principles of autonomy, beneficence, nonmaleficence, and justice.
- Professional boundaries are limits that protect the space between the nurse's professional power and the patient's vulnerabilities.
- Boundaries give each person in the relationship a sense of legitimate control, whether the relationships are between a nurse and a patient, a nurse and a physician, a nurse and an administrator, or a nurse and a nurse.
- Boundary violations and boundary crossings are two types of boundary departures that pose potential harm or exploitation and do not promote the best interest of another in the relationship.
- In addition to the ethical guidelines from the code of ethics, nurses must also follow the board of nursing's legal regulations and standards for practice in the nurse's state of residence. Violations can result in voluntary surrender, suspension, or revocation of the nurse's license, thus prohibiting the nurse from practicing. The boards of nursing function not to protect nurses, but to protect the public and ensure safe and competent care.
- If patients or their families file legal suits of negligence or malpractice in a civil court against a nurse, the plaintiff's lawyer must prove injury or harm to the plaintiff as a result of the nurse's negligence or malpractice.
- Thirteen interrelated ethical competencies, divided into three major competency areas, combine to form a well-defined, ideal nurse. The ethical competency areas are as follows: (1) moral integrity—honesty, truthfulness, benevolence, wisdom, and moral courage; (2) communication—mindfulness and effective listening; and (3) concern—advocacy, power, and culturally sensitive care.
- Nurses with moral integrity act consistently with their personal and professional values.
- Nurses experience moral distress when institutional constraints prevent them from acting in a way that is consistent with their personal and professional composite of moral integrity.
- Nursing involves hard moral choices that sometimes cause moral distress, resulting in emotional and physical suffering, painful ambiguity, contradiction, frustration, anger, guilt, and avoidance of patients.
- Research reveals a link between moral distress and the concepts of incompetent or poor care, unsafe or inadequate staffing, overwork, cost constraints, ineffective policy, futile care, unsuccessful advocacy, the current definition of brain death, objectification of patients, and unrealistic hope.

Key Points (continued)

- Truthtelling means nurses should not intentionally deceive or mislead patients. No matter how disappointing the news will be to patients and their families, nurses must evaluate the situation carefully with wisdom and contemplation before making any decision on the degree of information disclosure.
- Benevolent nurses will seek out ways to perform acts of kindness rather than only recognizing ways to do good.
- Aristotle viewed wisdom as an excellence that develops with intellectual accomplishment and practical expertise. Having wisdom, or practical wisdom, requires that nurses engage in a calculated intellectual ability, contemplation, deliberation, and effort to achieve a worthy goal.
- When nurses have the moral courage to do what they believe is the right thing in a particular situation, they make a personal sacrifice of possibly standing alone, but they will feel a sense of peace in their decision.
- Nurses must reside in a state of mindfulness and be an effective listener to develop good communication skills.
- Mindfulness requires paying attention in a particular way—on purpose, in the present moment, and nonjudgmentally.
- Effective listening means the communicators comprehend the actively exchanged information then form a mutual understanding of the essence of the dialogue.
- Concern means nurses feel a sense of responsibility to think about the scope of care that is important for their patients; sometimes a sense of worrying about the health or illness of patients prompts nurses to action.
- Patient advocacy, a competency of ethical nursing practice, requires nurses to embrace the promotion of well-being and to uphold the rights and interests of their patients.
- Nurses who are ingrained with the ideals of socialized power strive to benefit others with the intent to avoid harm or negative effects.
- Nurses' genuine attention to cultural diversity and the diversity within each culture promotes ethically competent care, which is essential in everyday nursing practice.
- Successful nurse–physician relationships require a mutual presence of three essential features: competence, respect, and trust. Reasons for strained nurse–physician relationships include the hierarchical way ethical care decisions are made, competency and quality-of-care conflicts, and lack of communication.
- Nurses often treat other nurses in hurtful ways. Many refer to this hurtful treatment as tall poppy syndrome or horizontal violence, but more recently it is referred to as workplace bullying, which involves interpersonal conflict, harassment, intimidation, harsh criticism, sabotage, and abuse.
- If stress and traumatic feelings are not managed properly, the effects lead to unproductive coping and unresolved issues. These traumatized nurses will function as the walking wounded.
- Wounded healers are informed by their own traumatic and difficult experiences that occur in the process of their everyday work, but also they transform their raw wounds to a healed scar that enables a better understanding of others' pain.
- Nurses can strengthen a sense of community within the profession by working to heal the disharmony and transform their anger to support nurses' accomplishments rather than treating them as tall poppies that must be cut down.

Key Points (continued)

- Nurses and physicians value their ability to use social media to retrieve minute-to-minute information, share knowledge, and build professional relationships. The use of social media has many benefits and also numerous perils.
- Social networking invokes questions of confidentiality and privacy when nurses, physicians, and patients share information with each other. The public nature of social communication poses ethical and legal problems, and solutions are usually unclear.
- Blurred-line behaviors and definite crossings occur, resulting from the use of social media when it invades the moral spaces of others and violates their privacy. What nurses could view as a flippant or innocent social media comment may be perceived by others as vulgar, inflammatory, or threatening.
- The growing number of employee violations worldwide that arise from social media are pushing employers to initiate disciplinary courses of action against their personnel and to enforce new policies to prevent inappropriate behaviors.

References

American Association of Critical-Care Nurses. (2004). *The four A's to rise above moral distress: ask, affirm, assess, act*. Retrieved from http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf

American Association of Critical-Care Nurses. (2008). *Position statement: Moral distress*. Retrieved from http://www.aacn.org/WD/Practice/Docs/Moral_Distress.pdf

American Medical Association (AMA). (2006). Opinion 8.082: Withholding information from patients. Retrieved from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8082.page

American Medical Association (AMA). (2011). Opinion 9.124: AMA policy: Professionalism in the use of social media. Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9124.page?

American Nurses Association (ANA). (2010a). *Nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: Author.

American Nurses Association (ANA). (2010b). *Nursing's social policy statement: The essence of the profession* (2010 Edition). Silver Spring, MD: Author.

American Nurses Association (ANA). (2011). *ANA's principles for social networking and the nurse: Guidance for registered nurses*. Silver Spring, MD: Author.

American Nurses Association (ANA). (2012). Position statements: Nursing care and do not resuscitate (DNR) and allow natural death (AND) decisions. Silver Spring, MD: Author. Retrieved from http://www.nursingworld.org/MainMenuCategories/Ethics-Standards/Ethics-Position-Statements/Nursing-Care-and-Do-Not-Resuscitate-DNR-and-Allow-Natural-Death-Decisions.pdf

American Nurses Association (ANA). (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.

Bazarko, D. (2014). *Mindfulness and you: Being present in nursing practice*. Silver Spring, MD: American Nurses Association.

Beauchamp, T. (2013, Winter). The principle of beneficence in applied ethics. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy*. Retrieved from http://plato.stanford.edu/archives/win2013/entries/principle-beneficence/

Beauchamp, T. L., & Childress, J. F. (2012). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). Thinking-in-action and reasoning-in-transition: An overview. *Clinical wisdom and interventions in critical care: A thinking-in-action approach* (pp. 1–26). Philadelphia, PA: Saunders.

Bennett, W. J. (Ed.). (1993). Honesty. In W. J. Bennett (Ed.), *The book of virtues: A treasury of great moral stories* (pp. 597–662). New York, NY: Simon & Schuster.

Broadie, S. (2002). Philosophical introduction. In S. Broadie & C. Rowe (Eds., C. Rowe Trans.), *Aristotle nicomachean ethics* (pp. 1–91). New York, NY: Oxford University Press.

Bu, X., & Jezewski, M. A. (2006). Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing, 57*(1), 101–110.

Butts, J. B. (2011). PRISMS—acronym for key action verbs for strategies to promote patient advocacy. Unpublished raw data.

Center for Mindfulness. (2014). History of MBSR. Retrieved from http://www.umassmed.edu/cfm/Stress-Reduction/History-of-MBSR/

Centers for Medicaid and Medicare Services (CMS). (1996). Health Insurance Portability and Accountability Act of 1996. Public Law 104-191, 104th Congress. Retrieved from http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/downloads/hipaalaw.pdf

Christie, W., & Jones, S. (2013). Lateral violence in nursing and the theory of the nurse as wounded healer. *Online Journal of Issues in Nursing*, *19*(1). doi:10.3912/OJIN.Vol19No01PPT01

Churchman, J. J., & Doherty, C. (2010). Nurses' views on challenging doctors' practice in an acute hospital. *Nursing Standard*, *24*(40), 42–47.

Conti-O'Hare, M. (2002). The wounded healer: Theoretical perspectives. *The nurse as wounded healer: From trauma to transcendence* (pp. 33–50). Sudbury, MA: Jones and Bartlett.

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636–650.

Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, *12*(4), 381–390.

Croke, E. M. (2003). Nurses, negligence, and malpractice: Continuing education. *American Journal of Nursing*, *103*(9), 54–63.

Davis, A. J., Fowler, M. D., & Aroskar, M. A. (2010). *Ethical dilemmas and nursing practice* (5th ed.). Boston, MA: Pearson.

Diemert, C. (2012). Protect your practice: Know your legal and ethical obligations. Nursing practice and education. *The Minnesota Nursing Accent*, *84*(1), 6–7.

Edson. M. (1999). *Wit*. New York, NY: Faber & Faber.

Ehrenreich, B., & English, D. (1973). *Witches, midwives, and nurses: A history of women healers*. New York, NY: Feminist Press.

Erichsen, E., Danielsson, E. H., & Friedrichsen, M. (2010). A phenomenological study of nurses' understanding of honesty in palliative care. *Nursing Ethics*, *17*(1), 39–50.

Esterhuizen, P. (2006). Is the professional code still the cornerstone of clinical nursing practice? *Journal of Advanced Nursing*, *53*(1), 104–113. (Original work published 1996)

Five nurses fired for Facebook postings. (2010, June 10). 10News.com. Retrieved from http://www.10news.com/news/23857090/detail.html

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

Fry, S. T., Veatch, R. M., & Taylor, C. (2011). Introduction. In S. T. Fry, R. M. Veatch, & C. Taylor (Eds.), *Case studies in nursing ethics* (4th ed., pp. xv–xxix). Sudbury, MA: Jones & Bartlett Learning.

Greater Good. (2010, May). *The stars of our own movie*. Retrieved from http://greatergood.berkeley.edu/gg_live/science_meaningful_life_videos/speaker/jon_kabat-zinn/the_stars_of_our_own_movie/

Greater Good. (2014). What is mindfulness? Retrieved from http://greatergood.berkeley.edu/topic/mindfulness/definition#what_is

Groesbeck, C. J. (1975). The archetypal image of the wounded healer. *Journal of Analytical Psychology*, *20*(2), 122–145.

Hakesley-Brown, R., & Malone, B. (2007). Patients and nurses: A powerful force. *The Online Journal of Issues in Nursing*, *12*(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No1-Jan-2011/Articles-Previous-Topics/AACN-Framework-and-Moral-Distress.aspx

Hamric, A. B. (2000). What is happening to advocacy? *Nursing Outlook*, *48*(3), 103–104.

Hanks, R. G. (2007). Barriers to nursing advocacy: A concept analysis. *Nursing Forum*, *42*(4), 171–177.

Holm, S. (2006). What should other healthcare professions learn from nursing ethics? *Nursing Philosophy*, *7*, 165–174.

Hwang, K.-K. (2001). The deep structure of Confucianism: A social psychological approach. *Asian Philosophy*, *11*(3), 179–204. doi:10.1080/09552360120116968

International Council of Nurses (ICN). (2012). *The ICN code of ethics for nurses*. Geneva, Switzerland: Author. Retrieved from http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

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

Johnson, C. E. (2012). Ethical interpersonal information. *Organizational ethics: A practical approach* (2nd ed., pp. 115–143). Thousand Oaks, CA: Sage.

Johnstone, M. J. (2008). *Bioethics: A nursing perspective* (5th ed.). Chatswood, Australia: Saunders Elsevier.

Kabat-Zinn, J. (2009). *Wherever you go, there you are: Mindfulness meditation in everyday life* (Adobe Digital Edition). New York, NY: Hyperion.

Kaplan, A. M., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of social media. *Business Horizons*, *53*(1), 59–68.

Katz, J. R. (2007). *A career in nursing: Is it right for me?* St. Louis, MO: Mosby Elsevier.

Kelly, C. (2000). *Nurses' moral practice: Investing and discounting self*. Indianapolis, IN: Sigma Theta Tau International Center Nursing Press.

Kidder, R. M. (1995). *How good people make tough choices*. New York, NY: William Morrow.

Laabs, C. (2011). Perceptions of moral integrity: Contradictions in need of explanation. *Nursing Ethics*, *18*(3), 431–440.

Lachman, V. D. (2007). Moral courage: A virtue in need of development? *MedSurg Nursing*, *16*(2), 131–133.

Lachman, V. (2010). Do-not-resuscitate orders: Nurse's role requires moral courage. *Journal of Medical Surgical Nursing*, *19*(4), 249–252.

Lipson, J. G., & Dibble, S. L. (2005). Introduction: Providing culturally appropriate health care. In J. G. Lipson & S. L. Dibble (Eds.), *Cultural and clinical care* (pp. xi–xviii). San Francisco: University of California, San Francisco, Nursing Press.

Loprinzi, C. L., Schapira, L., Moynihan, T., Kalemkerian, G. P., von Gunten, C., & Steensma, D. (2010). Compassionate honesty. *Journal of Palliative Medicine*, *13*(10), 1187–1191.

Lutzén, K., & Nordin, C. (1993). Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings. *Journal of Advanced Nursing*, *18*, 1106–1111.

Maes, S. (2003). How do you know when professional boundaries have been crossed? *Oncology Nursing Society*, *18*(8), 3–5.

Malloy, D. C., Hadjistavropoulos, T., McCarthy, E. F., Evans, R. J., Zakus, D. H., Park, I., . . . Williams, J. (2009). Culture and organizational climate: Nurses' insights into their relationship with physicians. *Nursing Ethics*, *16*(6), 719–733.

McCue, C. (2011). Using the AACN framework to alleviate moral distress. *The Online Journal of Nursing Issues*, *16*(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No1-Jan-2011/Articles-Previous-Topics/AACN-Framework-and-Moral-Distress.aspx

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing*, *42*(1), 90–96.

National Council of State Boards of Nursing (NCSBN). (2011a). *A nurse's guide to professional boundaries*. Chicago, IL: Author. Retrieved from https://www.ncsbn.org/Professional Boundaries_Complete.pdf

National Council of State Boards of Nursing (NCSBN). (2011b). *A nurse's guide to the use of social media*. Chicago, IL: Author. Retrieved from https://www.ncsbn.org/NCSBN_SocialMedia.pdf

National Council of State Boards of Nursing (NCSBN). (2011c). *State and territorial boards of nursing: What every nurse should know*. Chicago, IL: Author. Archived at https://www.ncsbn.org/3748.htm

National Council of State Boards of Nursing (NCSBN). (2011d). *White paper: A nurse's guide to the use of social media*. Chicago, IL: Author. Retrieved from https://www.ncsbn.org/Social_Media.pdf

Pearce, E. C. (1975). The patient. *A general textbook of nursing* (19th ed., pp. 3–10). London, UK: Faber & Faber.

Pellegrino, E. D., & Thomasma, D. C. (1993). Phronesis: Medicine's indispensable virtue. *The virtues in medical practice* (pp. 84–91). New York, NY: Oxford University Press.

Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing Economics*, *25*(4), 217–221.

Pinch, W. J. E. (2009). Honoring American nurse ethicists. *Nursing Ethics*, *16*(2), 238–246.

Plante, T. G. (2004). *Do the right thing: Living ethically in an unethical world*. Oakland, CA: New Harbinger.

Ponte, P. R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrrell, R., . . . Washington, D. (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). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/tpc32_316092.aspx

Pullon, S. (2008). Competence, respect, and trust: Key features of successful interprofessional nurse–doctor relationships. *Journal of Interprofessional Care*, *22*(2), 133–147.

Purnell, L. (2002). The Purnell model of cultural competence. *Journal of Transcultural Nursing*, *13*(3), 193–196.

Purnell, L. (2011). Models and theories focused on culture. In J. B. Butts & K. L. Rich (Eds.), *Philosophies and theories for advanced nursing practice* (pp. 525–568). Sudbury, MA: Jones & Bartlett Learning.

Redman, B. K., & Fry, S. T. (2000). Nurses' ethical conflicts: What is really known about them? *Nursing Ethics*, *7*, 360–366.

Robb, I. H. (1916). *Nursing ethics: For hospital and private use*. Cleveland, OH: E. C. Koeckert. (Original work published 1900)

Rowe, C., & Broadie, S. (Eds.). (2002). *Aristotle nichomachean ethics* (C. Rowe, Trans.). New York, NY: Oxford University Press.

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics*, *15*(3), 304–321.

Spector, R. E. (2012). *Cultural diversity in health and illness* (8th ed.). Upper Saddle River, NJ: Pearson-Prentice Hall.

Stein, L. I. (1967). The doctor–nurse game. *Archives of General Psychiatry*, *16*(6), 699–703.

Stein, L. I., Watts, D. T., & Howell, T. (1990). The doctor–nurse game revisited. *Nursing Outlook*, *38*(6), 264–268.

Stenburg, M. J. (1988). "The responsible powerless": Nurses and decision about resuscitation. *Journal of Cardiovascular Nursing*, *3*, 47–56.

Sulmasy, D. P., He, M. K., McAuley, R., & Ury, W. A. (2008). Beliefs and attitudes of nurses and physicians about do not resuscitate orders and who should speak to patients and families about them. *Critical Care Medicine*, *36*(6), 1817–1822.

Swift, A. (2013). Honesty and ethics rating of clergy slides to new low: Nurses again top list; lobbyists are worse. Retrieved from http://www.gallup.com/poll/166298/honesty-ethics-rating-clergy-slides-new-low.aspx

Thomas, S. P. (2009). *Transforming nurses' stress and anger: Steps toward healing* (3rd ed.). New York, NY: Springer.

Tschudin, V. (2006). 30th anniversary commentary "Is the professional code still the cornerstone of clinical nursing practice?" *Journal of Advanced Nursing*, *53*(1), 112–113.

Turnbull, D. (2003). Genetics and disability: Exploring moral space. *Journal of Future Studies*, *7*(4), 3–14.

U. S. Department of Health and Human Services. (2003). *Summary of the HIPAA privacy rule*. Washington, DC: Author. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Vaartio, H., Leino-Kilpi, H. Salanterä, S., & Suominen, T. (2006). Nursing advocacy: How is it defined by patients and nurses, what does it involve and how is it experienced? *Scandinavian Journal of Caring Science*, *20*, 282–292.

Volker, D. L. (2003). Is there a unique nursing ethic? *Nursing Science Quarterly*, *16*(3), 207–211.

Wright, D., & Brajtman, S. (2011). Relational and embodied knowing: Nursing ethics within the interprofessional team. *Nursing Ethics*, *18*(1), 20–30.

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Journal of Psychotherapy*, *49*(4), 482–491.

Zurik, L. (2012, May 22). Lee Zurik investigation: Nurse witnesses patient mistreatment. Retrieved from http://www.fox8live.com/Global/story.asp?S=17219276