

Chapter 20

NURSING ETHICS AND THE MILITARY

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This untitled painting, signed “Ramus ‘45,” suggests the adoration for the US Army Nurse so often expressed by the wounded GIs whose lives they help to save.

Art: Courtesy of US Army Medical Department Museum, Fort Sam Houston, Texas.

INTRODUCTION

Although the care and comfort of the sick and injured is a critical component of every war, military leaders and the public, in general, have traditionally given little attention to these healthcare professionals. Most of the acknowledgment and gratitude they have received was from those who had the unfortunate occasion to experience the compassionate service provided by nurses during wartime. Almost every veteran injured in battle and cared for by nurses far from home has his story to tell. This was probably never more evident than on Veterans' Day, 1993, in Washington, DC, when the Vietnam Women's Memorial was dedicated. More than 30,000 people turned out for the dedication of the first visible symbol in the nation's capital to honor women's patriotic service. Many attending were veterans, those who had been cared for and those who provided that care, each seeking the other to share a special bond formed years ago in faraway places.

Nurses have often been called the "forgotten veterans" because their role under the unique circumstances of war has not been well understood, even though nursing is an occupation known to everyone. In hostile and unfamiliar surroundings and separated from loved ones, the tradition of military nurses has been to steadfastly continue their practice of caring for others. In this stressful environment, they witness and experience the extremes of human behavior in others and in themselves. Nurses do experience "war," not necessarily in the sense of a combatant, but rather the larger, moral picture of war—its cost measured in its casualties.¹

The professional strains and moral dilemmas experienced by today's military nurses, for the most

part, are not different from those experienced by their civilian counterparts working in trauma centers or prison health systems. What is unique is that during wartime, a great number of stressful experiences often occur in a compressed period of time, usually away from traditional, personal support systems. Also, the situation of displaced persons, refugees, and those who suffer collateral injuries adds another dimension. Although all female professional nurses have been volunteers in the US military services, the experience may not always have turned out to be what was perceived or expected and the location may not have been one of the individual's choices. Some of the moral dilemmas that have been reported will be shared in this chapter.

The development of military nursing throughout modern history has had intricate associations with the private nursing sector and the status of women in society. As the nursing profession has evolved over time, so has the concept of nursing ethics. Several leaders in the evolution of modern civilian nursing also influenced military nursing as their careers intersected with the Army during wartime. From the time of Nightingale and the Crimean War to current, diverse healthcare settings from hospitals to security and sustainment operations, nurses in the military environment continue to struggle with challenging ethical issues involving their patients and the practice and profession of nursing. This chapter will review the history of early nursing ethics, trend the development of the ethical code for nurses, explore how nursing and medicine view ethical decision making, and discuss the resolution of ethical dilemmas.

EARLY NURSING ETHICS

During the Revolutionary War, camp followers on both sides of the war were women who cooked, cleaned, washed, and sewed. Those who tended the sick and wounded were known as nurses, although the extent of their previous experience may have been tending to an ailing family member. After all, the word nurse (*nutricia* or nourishing) means a person who is skilled or trained in caring for the sick or infirm.

In 1775, General Horatio Gates reported to General Washington that "the sick suffered much for Want of good female Nurses." In turn, General Washington asked the Congress for "a matron to supervise the nurses, bedding, etc," and for nurses

"to attend the sick and obey the matron's orders." The medical support plan provided one nurse for every 10 patients and "that a matron be allotted to every hundred sick or wounded, who shall take care that the provisions are properly prepared; that the wards, beds, and utensils be kept in neat order, and that the most exact economy be observed in her department." In spite of these references to nursing, it was not recognized as a separate and distinct service.²

Later, as Lady Superintendent in Chief of female nurses in the English General Military Hospitals during the Crimean War, Florence Nightingale promoted military nursing when she organized a group

of nurses for war service in Turkey in 1854. She battled to improve sanitary conditions and acceptance of female nurses. She understood medical and military politics and used statistical data, keen writing skills, and good social connections to achieve her purposes. Many of the early ethical issues in nursing arose from the image that nurses were women of dubious reputation and nursing was a task viewed as being neither as lowly as a simple domestic, nor as highly placed as a cook. Overcoming this image of nursing was a great challenge to Florence Nightingale when she started the Nightingale School of Nursing in 1860 at St. Thomas's Hospital, London.

During the same period in the United States, Dorothea L. Dix, known for improvement in the care of the mentally ill, had responded to President Lincoln's call for volunteers to help care for sick and injured soldiers. Appointed Superintendent of the Female Nurses of the Union Army in 1861, she initially set strict criteria for her nurses but, due to the great need, later appointed almost any woman willing to serve. As the war continued, there was no single system for recruiting and preparing nurses; few had actual preparation beyond family experiences. The acceptance of female nurses near the battlefield varied with the intensity of need. They also tended to anger the hierarchy with their letter writing. Having learned that letters were the lifeblood between the injured and their families, Civil War nurses used this woman-to-woman communication link to arouse and maintain pressure for the flow of needed supplies from private and charitable sources when the supply system failed. They wrote about unsafe conditions and, on occasion, unsafe medical practice, taking sanitation and organization into their own hands. The many women, known and unknown, who organized relief agencies and served as nurses changed forever the concept of women's roles. The Civil War is credited as setting the stage for the emergence of women from home to larger societal purpose, the development of professional nursing in the United States, and the inclusion of trained women nurses in military organizations.³

During the remainder of the century, it was traditional for ethical issues in nursing to focus on etiquette as the first formal schools of nursing attempted to attract the respectable and educated daughters of families from the middle classes. Morals and manners were emphasized as necessary characteristics for a woman to possess or acquire to be a successful nurse. The extent to which ethical considerations were pursued in the curricula is unclear. Yet, it is

noted that students of the Johns Hopkins School of Nursing were taught ethical issues soon after the opening of the school in 1889.⁴

At the onset of the Spanish-American War, Dr. Anita Newcomb McGee, Vice President of the National Society of the Daughters of the American Revolution, was placed in charge of selecting graduate nurses for the Army. The Army Medical Department reluctantly called for the nursing services of women when unable to enlist enough male medics qualified by previous experience to perform important patient care duties and because of the epidemic prevalence of typhoid fever in Army camps. The record of service of the women nurses who served in this war was a convincing factor in the establishment of a permanent nurse corps (as well as a memorial in Arlington Cemetery; see Figure 20-1). In spite of some reluctance on the part of Surgeon



Fig. 20-1. The Nurses Memorial. This marble statue honoring military nurses is located on a knoll in Section 21 of Arlington National Cemetery where hundreds of nurses are buried. The sculpture, by Frances Rich, was originally dedicated on 8 November 1938 to commemorate Army and Navy nurses. It was rededicated on 20 November 1970 to include Air Force nurses as well as all nurses who had served since 1938.

General George M. Steinberg and some senior medical officers, the Nurse Corps (female) became a permanent corps of the Army Medical Department on 2 February 1901.²

Following this, there was great interest in the Medical Department of the Navy to formalize a nurse corps. Nursing in the Navy was originally carried out by members of the ship's crew who were untrained and held no special status until establishment of the Hospital Corps in 1898. The Nurse Corps (female) of the US Navy, established by law on 13 May 1908, met with some resistance among military doctors. Navy nurses charted new territory, however, and their first superintendent, Esther V. Hasson, predicted in 1909:

One of the principle [*sic*] duties of the woman nurse in the Navy will be the bedside instruction of the hospital apprentices in the practical essentials of nursing....When treatment, baths, or medication come due it is not expected or desired that she will always give these herself, but it will be her duty to see that the apprentices carry out the orders promptly and intelligently. This arrangement does not, however, absolve the nurse...from doing the actual nursing work whenever necessary...she is always expected to keep uppermost in her mind... the improvement of the apprentices to whom the bulk of the nursing of the Navy afloat will always fall, for it is not the intention of the Surgeon General to station women nurses on any but hospital ships.⁵

In 1917, Annie W. Goodrich, president of the American Nurses Association, was appointed under contract as Chief Inspector Nurse of the Army. Her unfavorable report on utilizing nurses' aides in Army hospitals called for more trained nurses. She subsequently became Dean of the first Army School of Nursing, authorized in 1918 by the Secretary of War. Sometime in the 1920s, the second Dean and first Superintendent of the Army Nurse Corps, Major Julia C. Stimson, began to teach ethics.

Major Stimson's notes reveal that she held the

ethics course as an open forum with the students, assigning four problems each week for discussion. One section of her notes listed 22 discussion points ranging from simplistic to philosophical. Examples included:

- To what extent is dress involved in the question of nursing ethics? Trace the historical development of the uniform and the current observance in regard to the uniform in public places, wearing jewelry, etc.
- Discuss the following questions from the standpoint of nursing ethics. Smoking, bobbed hair, use of cosmetics, drinking, rule of seniority, class distinction, tipping, and presents.
- What is the main contribution of nursing ethics made by the following: Hippocrates, St. Paul, Jerome, St. Francis, Elizabeth of Hungary, Luther, Edith Cavell, Deaconesses, Monasteries, St. Vincent de Paul, John Howard, The Fleidners, Charles Dickens, Florence Nightingale, Dorothea Dix, Knights Hospitallers, Secular Orders.⁶

These topics were typical of ethical discussions at the time. Major Stimson also included the definitions of ethics and nursing ethics attributed to Isabel Hampton Robb. Mrs. Robb's text, *Nursing Ethics for Hospital and Private Use*, addressed posture, table manners, and appropriate wardrobe for a nurse, but also covered health, education, and culture as necessary qualifications for nursing. An outstanding nurse of the day, she had been instrumental in initiating two national nursing associations and an official journal for nurses. Many considered her book to be a great step toward professionalism in nursing. Nursing leaders acknowledged that, although women could be trained to be nurses, character could not be changed. Character was important for members of the emerging profession. Nursing had begun to move from ethical issues of personal morality to professional ethics.

ETHICAL STANDARDS FOR NURSES

Meanwhile, the first generally accepted written code for nursing in the United States had been formulated in 1893. A committee under the leadership of Lystra E. Gretter, principal of the Forrand Training School for Nurses in Detroit, developed the pledge to serve as guide for the ethical behavior of nurses until a formal code of ethics was completed. It was patterned after medicine's Hippocratic Oath

and named after Florence Nightingale, whom Gretter felt embodied the highest ideals of nursing. The Nightingale Pledge, still frequently administered at many nursing school graduations today, reads as follows:

I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity

and to practice my profession faithfully.

I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession.

With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.⁷

The Nurses' Associated Alumnae of the United States and Canada, forerunner of the American Nurses' Association (ANA), sought to establish and maintain a code of ethics for the purpose of promoting ethical standards in all the relations of the nursing profession as early as 1896. Nurses wanted something concrete they could use as a basis for professional conduct and in teaching ethics. The legacy of these early efforts is the "Code of Ethics for Nurses With Interpretive Statements."⁸⁻¹⁰

Since its inception, nursing's code of ethics has undergone periodic revisions in order to remain relevant. Changes in the code were influenced by the growth of nursing toward professionalism and by changes in nursing, society, and healthcare. Yet, the ethical norms of the profession, the moral duties, and the values of the profession have remained constant. First, "A Suggested Code," presented in 1926, reflected values of "Christian morality" and attitudes toward nursing at that time. Nurses were viewed as obedient, submissive to rules, adept in social etiquette, and loyal to the physician. Nursing was considered to be an emerging profession meeting a basic human need. Nursing and medicine were viewed as distinct but complementary disciplines characterized by mutual respect. The 1926 code was replaced by "A Tentative Code" in 1940. The intent was to recognize nursing as a profession. It cited the responsibility of the nurse in relationships to the patient, other nurses, the employer, the public and others, as well as responsibility to oneself. Guidance was provided for specific situations rather than a broad framework that could be applied in a variety of situations. The concept of research as a means of improving care was introduced for the first time.

Ten years passed before the code was altered again. Undoubtedly the entry of the United States into World War II contributed to the hiatus in fur-

ther development. The country was faced with a critical shortage of registered nurses nationwide. To help meet nursing personnel requirements, the United States Cadet Nurse Corps was established under the administration of the United States Public Health Service. This measure set the precedent that schools of nursing were recognized as essential agencies in the protection of the nation's health. During this period, the Army Nurse Corps began specialty training in anesthesiology, operating room procedures, and public health nursing. In 1942, Navy nurses were given a status called "relative rank," which had been afforded to Army nurses in 1920. The Army-Navy Nurse Act of 1947 provided permanent commissioned officer status for registered nurses in the armed services, and Public Law 36, 80th Congress, established the Army Nurse Corps (ANC) in the Medical Department of the Regular Army. On 1 July 1949, the US Air Force Nurse Corps was established. A total of 1,999 Army nurses transferred to the US Air Force, forming the nucleus of its Nurse Corps. The status of commissioned officers assisted military nursing in its efforts to change outmoded ideas and pave the way for the nursing profession.^{2(p23),11}

The revised "Code for Professional Nurses," unanimously accepted by the ANA in 1950, consisted of a brief preamble and 17 succinct, enumerated provisions. The word "professional" was used to describe the nurse and the statement about loyalty to the physician was omitted. The prevention of illness and promotion of health by teaching and example were included as expectations of nursing.

Then, in 1953, the International Council of Nurses (ICN) adopted an international code of ethics for nurses to serve as the standard for nurses worldwide. The 14 statements cited the responsibility of nurses to conserve life, alleviate suffering, and promote health. Nurses were expected to refuse to participate in unethical procedures, report unethical conduct of associates but only to the proper authority, and to adhere to standards of personal ethics in their professional and private lives. Although minor revisions were made at various times, a new version was not released until 27 years later, responding to the realities of nursing and healthcare in a changing society.¹²

Further amendments to the ANA code, in 1956 and 1960, addressed nurse participation in advertising professional services and in setting terms and conditions of employment. During this decade, attention shifted from concern for content of the code to concern about its enforcement in the practice setting. It was also during this time that the armed

services commissioned male registered nurses. Men, as medics, were a tradition in military medicine. In 1951, the Department of Defense (DoD) established a definitive policy (DoD Directive 750.04-1, renumbered 1125.1) on the utilization of registered nurses in the military services and instructed the military medical services to establish programs to train and utilize enlisted personnel as practical nurses and in other paraprofessional nursing roles providing patient care.^{2(pp25-28)} The same year, Congresswoman Frances P. Bolton introduced HR 911 in an attempt to provide for the appointment of men as nurses in the US Army, US Navy, and US Air Force. Finally in 1955, Public Law 294, 84th Congress, again introduced by Congresswoman Bolton, authorized commissions for male nurses in the US Army Reserve for assignment to the ANC Branch. The first man to receive a commission in the ANC was a nurse anesthetist in the fall of 1955. Men were eligible for the Army Student Nurse Program established the next year to help solve the acute shortage of nurses in the Army. Finally, in 1962 men were authorized to apply for the Registered Nurse Student Program that had been established in 1953 to recruit registered nurses for the ANC. Thereafter, educational opportunities for men and women were equal.²

The social upheaval of the 1960s, along with major improvements in the capabilities of healthcare delivery, forced reevaluation of what nurses and nursing stood for in society. Nurse practitioners appeared on the healthcare scene in 1965 when nurse Loretta Ford and physician Henry Silver at the University of Colorado educated nurses to provide primary care for children and their families. The nurse practitioner movement, an approach to fill the physician gap to provide primary care to children and those unable to pay, was enhanced by social agitation to fund educational programs and gained energy from the women's movement in this attempt to broaden nursing practice. Although initially supportive of this professional nursing development, organized medicine has since sought to constrain the scope of practice for nurse practitioners.¹³

The substantive revision in 1968, the "Code for Nurses," dropped the word "professional" from the title to indicate that the code applied to both professional and technical nurses. For the first time, references to personal ethics were omitted. This was a significant departure from the early focus of nursing educators and administrators on questions of the moral purity of the probationer, trainee, and graduate.⁹ Instead of referring to the physician, this version referred to members of other health professions. The 1968 Code provided nurses an ethical

framework within which to practice their profession by addressing their responsibility to the patient, society, and the profession, and by participating in research.¹⁴

During this period, several thousand nurses who served in Vietnam began to return to the private sector. Although politicians, historians, and others have said that the Vietnam conflict was different from other American wars, a review of the literature reveals that the fundamental experience of wartime for nurses was not much different. The youth of the patients, the severity of injury, the lack of feedback on patients' progress after transfer, the patient deaths that could not be prevented, the deaths of friends, working with enemy patients, and dealing with the triage situation are frequently cited as stressors. Although caring for young wounded casualties was reported to be stressful, it was also considered to be gratifying. Like nurses who served in World War I, World War II, or the Korean War, these nurses felt a common pride in their accomplishments and the wartime role of the professional, although these feelings may have been tempered by the social and political circumstances. Returning to stateside nursing often required a considerable adjustment, from the clinical responsibility and collaborative teamwork practiced in the war, to the more restrictive roles still found in many settings. The profession was just beginning to achieve autonomy. The structured healthcare environment was very different from Vietnam. Some nurses became angry and disillusioned about nursing practice, some reverted to traditional roles, and others took up the challenge to promote the status of the nursing profession.^{15,16}

Further changes in nursing and its social context led to an update of the ethical code in 1976. The "Code for Nurses With Interpretive Statements" placed new emphasis on the responsibility of the patient to participate in his own care (self-determination), the notion of nursing autonomy, and the nurse's role as client advocate. The word "client" rather than "patient" was used in an attempt to be less restrictive and to imply a more egalitarian relationship. However, "client" implies that the recipient of care can make a choice of care provider. Yet, the bulk of nursing practice does not include that type of choice on the part of recipients and may connote unintended change in the nurse-patient relationship.¹⁷ The ANA also formed a Committee on Ethics that later published "Guidelines for Implementing the Code for Nurses."

The 1985 revision of the Code for Nurses retained all 11 provisions unchanged from 1976. The pre-

amble, however, included a list of fundamental principles of ethics and the interpretations more closely reflected these principles and placed greater emphasis on patients' rights. For example, a reference to healthcare as a right of all citizens was changed to reflect the availability and accessibility of high-quality health services to all people. The Code for Nurses reflected nursing's changing relationship to society and the societal concerns of the times.¹⁸ During the mid-1990s, both organized nursing and the media promoted "advance practice nurses" as one solution to a serious component of America's healthcare crisis—the need for greater access to routine primary and preventive care. This group of nurse practitioners, nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists represented 100,000 nurses who generally had 18 months to three years of graduate education beyond the baccalaureate, many with a master's degree.

Countless studies and analyses documented the quality of care delivered by these direct care providers. Yet, every advance in their reimbursement for services and broader prescriptive authority in-

involved protracted negotiation within the healthcare community. Professional challenges for these providers must continue to be addressed within the framework that nurses value the distinctive contribution of individuals or groups and collaborate to meet the shared goal of providing quality health services. Also, in the 1990s both the ANA and the ICN initiated comprehensive reviews of their codes. Each organization wanted to reflect current ethical standards for nurses—to make explicit the primary goals, values and obligations of the profession. The revised "ICN Code of Ethics for Nurses," adopted in 2000, begins with a very powerful preamble:

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect. Nursing care is unrestricted by considerations of age, color, creed, culture, disability or illness, gender, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.^{18(p2)}

EXHIBIT 20-1

THE 2001 "CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS"

- The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
- The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
- The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
- The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
- The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
- The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
- The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Reproduced with permission from *Code of Ethics for Nurses With Interpretive Statements* (ISBN 1-55810-176-4). Washington, DC: American Nurses Publishing; 2001: 4.

The ICN Code comprises four elements: (1) nurses and people, (2) nurses and practice, (3) nurses and co-workers, and (4) nurses and the professions. These elements provide a framework for standards of ethical conduct.

The “Code of Ethics for Nurses with Interpretive Statements” adopted by the ANA in 2001 complements the ICN document. It provides a succinct statement of the ethical obligations and duties of every nurse, sets the profession’s nonnegotiable ethical standard, and expresses nursing’s own understanding of its commitment to society.^{19(p5)} The Code comprises nine provisions: three describe fundamental values and commitments of the individual nurse, three address expectations for optimal performance and loyalty to self and others, and three address responsibilities to the profession and community at large (Exhibit 20-1). The interpretative statements for each provision provide greater specificity for practice within the contemporary context of nursing. Again, the word “patient” is used to refer to recipients of nursing care, although it is acknowledged that the Code applies to nurses and

recipients of their services in all roles and settings.

The “Code of Ethics for Nurses” informs both the nurse and society of the profession’s expectations and requirements in ethical matters. It provides a framework within which nurses can make ethical decisions and discharge their responsibilities to the public, other members of the healthcare team, and the profession. These decisions are based on consideration of consequences and of universal moral principles, both of which prescribe and justify nursing actions. Although the core value is respect for persons, there is deep and abiding concern for fundamental ethical principles including: autonomy (self-determination), nonmaleficence (avoiding harm), beneficence (doing good or positively benefiting another), veracity (truth telling), fidelity (keeping promises), confidentiality (respecting privileged information), and justice (treating people fairly). In summary, the nurse’s daily practice is charged with compromise and compassion, along with patient advocacy—feelings that greatly influence and modify the work ethics of the nursing profession. Table 20-1 provides a summary of the evolution of the codes for nursing.

NURSING AND MEDICINE

The emphasis on nursing as a profession was driven, in part, by the desire to shed the generally inferior social and economic status assigned to nurses in the medical hierarchy. By becoming professionals, nurses would enter the middle class and so achieve a social parity with other middle-class professionals, including physicians.²⁰

The authority for nursing, as for other professions, is based on a social contract between society and the profession. Society grants the professions authority over their essential activities and permits considerable autonomy in the conduct of their affairs. The professions, in turn, are expected to act responsibly, ever mindful of the public trust, and to self-regulate to assure quality performance. The social contract for nursing has been made specific, over the years, through multiple actions. These actions include: (a) developing a code of ethics, (b) standardizing nursing curricula, (c) establishing educational requirements for entry into professional practice, (d) procuring registration for graduates of nursing programs, (e) establishing standards of practice, (f) developing a body of knowledge derived from nursing research, (g) developing certification processes for the profession, and (h) other works directed toward making more specific nursing’s accountability to society.²⁰ Nurses are ethically and legally accountable for actions taken in

the course of nursing practice as well as for actions delegated by the nurse to others assisting in the delivery of nursing care. Individual moral responsibility requires a willingness to act on one’s moral beliefs and to accept accountability for one’s actions.

Traditional ethical questions in healthcare involving issues such as euthanasia, abortion, experimentation, rationing, truth telling, and so forth, appear to be the same for all healthcare professionals. Other underlying principles or values for patient care are also shared. These include: (a) acting in the best interest of the patient, (b) protecting patient confidentiality and dignity, (c) obtaining informed consent for at-risk procedures, (d) obtaining consultations when believed necessary, and (e) respecting the scientific method. Acting in the best interest of the patient is an important component of the physician–patient covenant and the relationship of other healthcare professionals to the patient (including but not limited to the nurse). This is important due to the vulnerability and anxiety often felt by the patient, an inability to care for his health at this particular time, and potentially limited knowledge to determine whether the recommended course of treatment is indeed most beneficial.

“Nursing” is defined as the diagnosis and treatment of the human responses to actual or potential health problems. It is the human response that re-

TABLE 20-1
SUCCESSIVE REVISIONS OF THE CODE OF ETHICS FOR NURSES

DATE/TITLE	REFLECTION OF CONTENT	RATIONALE FOR CHANGES
1893 Florence Nightingale Pledge	First generally accepted, but unofficial, code of ethics.	Response to the felt need of many nurses to have their own pledge or oath.
1926 A Suggested Code	The nurse is primarily a citizen and public servant; obedient, trustworthy, loyal, and adept in social etiquette. Criteria for professional status includes registration in one state. Nursing responsibility includes safeguarding the health and property of patients. Medicine and nursing are distinct but complementary entities; however, nursing will not initiate treatment except in emergency.	First ANA attempt to adopt official code of ethics. Reflects nursing as meeting a basic human need and emerging as a profession.
1940 A Tentative Code	The nurse is responsible to her profession (shifted emphasis away from citizen and servant). Further enumeration of professional criteria. Loyalty to the physician demands that the nurse conscientiously follows his instruction. Emphasizes disease prevention and health promotion, stressing the nurse's health-teaching role. Introduces research as a means for improving nursing care.	Declares nursing a profession. Expresses overt concern for the status and public recognition of nursing as a profession.
1950 Code for Professional Nurses	Incorporates many elements of professional relationships within the Code's provisions. Omits the statement about loyalty to the physician. Softens the statement about treatment by using the term "medical treatment."	First national code of nursing ethics for any country. Uses "professional" in the title to emphasize nursing as a profession. Begins to identify patient care functions (nursing treatments) within its purview. Addresses questions and problems regarding nurses and advertising.
1953 International Code of Nursing Ethics	Provides a prescriptive list of acceptable standards for the nursing profession.	Attempts to define a code of ethics applicable to nursing worldwide.
1956 Code for Professional Nurses, Amended	Nurses may disseminate scientific findings without intention to endorse or promote commercial products or services used in studies. Nurses or groups of nurses may advertise professional services in conformity with the standards of the nursing profession.	Growing numbers of nurse researchers and authors seek to advertise their own publications and to present research findings that may reference commercial products.

(Table 20-1 continues)

Table 20-1 *continued*

1960	Code for Professional Nurses, Revised	<p>Membership and participation in the professional organizations and participation in defining and upholding standards of practice and education is expected.</p> <p>References the dependent and independent functions of nursing.</p> <p>Allows active participation in setting terms of employment.</p>	<p>Attention shifts from concern for content to concern about enforcing the code in the practice setting.</p> <p>The association of the word “plank” with political meaning is intentional when referring to the description of each statement.</p>
1968	Code for Nurses	<p>Deletes the term “professional.”</p> <p>Deletes all statements about physicians.</p> <p>Deletes all references to “personal ethics.”</p> <p>Addresses the nurse’s responsibility to the patient, society, and the profession.</p> <p>Includes nurse participation in research.</p>	<p>Applies to all registered nurses, graduates of hospital schools, technical colleges, and universities in response to controversy over the definition of technical and professional nurse.</p> <p>The personal sphere is no longer deemed within the purview of professional scrutiny.</p> <p>Reflects the social upheaval of the 1960s and major innovations in healthcare delivery.</p>
1976	Code for Nurses With Interpretive Statements	<p>Deletes sexist language and refers to “client” rather than “patient.”</p> <p>Interpretive statements emphasize self-determination of the client and the nurse’s role as client advocate.</p> <p>Notes the obligation to contribute to the profession’s development noted, including research.</p>	<p>Uses nonsexist terminology and the word “client” to reflect nursing’s attempt to be more inclusive.</p> <p>Response to sensitivity regarding patient rights, informed consent, and shared decision making.</p> <p>Reference to nursing autonomy and nurse-as-advocate reflects respect for the autonomy of the patient and the nurse.</p>
1985	Code for Nurses With Interpretive Statements, Revised	<p>Includes fundamental principles of ethics.</p> <p>Updates interpretations, referring to “people” instead of “citizen,” for example.</p>	<p>The ethical principles are reflected in the content of the interpretative statements.</p> <p>Places greater emphasis on inclusion, eligibility, and patient rights.</p>
2000	The ICN Code of Ethics for Nurses	<p>Respect for human rights is inherent in nursing.</p>	<p>Responds to the realities of nursing and healthcare in a changing society. Guide for action based on social values and needs. Supports refusal of nurses to participate in activities that conflict with caring and healing.</p>
2001	Code of Ethics for Nurses With Interpretive Statements	<p>There are 9 provisions instead of 11. The word “patient” is used again and “practice” is used to refer to the actions of the nurse in all roles and settings.</p>	<p>The provisions are more generalized in content and the accompanying interpretive statements reflect the contemporary context of nursing.</p>

mains the defining characteristic of nursing that distinguishes it from medicine and the other health professions. Nursing views the patient as a holistic being. The goal of nursing is identification of human needs and actions appropriate in response to

those needs. When engaged in the process of making ethical choices in the clinical judgment process, nurses tend to focus their cost-benefit analyses around the impact of patients’ problems on quality of life, emotional and physical suffering, and de-

gree of human function based on respect for persons.²¹ For example, while taking a nursing history or providing physical care for a patient, the nurse will pick up cues on how the individual interacts within his personal, family, and community systems. This information is often helpful in assisting the individual to cope with, or adjust to, the specific health need that initiated their interaction. Nurses frequently serve as an intermediary between patient and physician, encouraging the patient to ask questions he wants answered, and interpreting, explaining, or reaffirming information provided by the physician. The nurses' psychology tends toward an unconditional love for patients under their care, which also affects the daily ethical behavior of nurses.

Medicine is described as the science and art of preventing, alleviating, and curing disease. By extension, any issue or problem deriving from that generic body of knowledge and any application of it belongs to the general category of medical concern.²² Physicians typically evaluate and diagnose the presenting problem, prescribe the necessary interventions, and arrange follow-up as needed. They tend to focus their cost-benefit analyses around what is viewed as their primary duty to control, diminish, or eradicate the disease and its effect.²¹ Physicians' concerns related to quality of life (particularly when considering withdrawing life-sustaining treatment for terminally ill patients), economic factors, and length of stay reflect the profession's increasing concern about the cost of care and the proper use of resources.²³ Physicians have not historically become as involved in patients' psychosocial systems and responses as do nurses. A dramatic example, as told by a colleague, illustrates this difference:

A surgical team from a highly developed country was working in a foreign nation where the motor scooter is a primary means of personal transportation. A below-knee-amputation was performed on a young wife wounded by an antipersonnel land mine. Due to ensuing severe toxicity, the surgeon recommended a hip disarticulation to assure saving the patient's life. The nurse argued for an above-knee-amputation as an intermediate step so that riding on a scooter would still be possible. A hip disarticulation was performed and the patient was prepared for discharge. When her husband arrived to pick her up, she was unable to balance on the back of his scooter. He drove away without her and the patient died, "heartbroken," two weeks later.²⁴

This example illustrates that the practice of medicine tends toward the disease-fighting model, concentrating on the application of research and cure.

The healthcare system—from medical education to reimbursement—calls physician attention to sick cells, organs, tissues, and limbs rather than relating to the patient. By contrast, nursing tends toward the psychological and social meaning of illness, concentrating on patient advocacy and care. Although it is absurd to say that nurses care while physicians cure (because in reality physicians try to help their patients cope with the experience of illness, and, of course, nurses help patients to be cured), there is nonetheless a distinct difference between nursing and medicine.

Theories on differences in behavior date back to the ancient Greeks, as shown in the *Corpus Hippocraticum*, regarding the doctor-patient relationship. The formulation of their bond was established on the basis of love of nature through a specific man, the patient. Because of his disease, a sick man is a good friend to a doctor. In the case of the physician, it is assumed where there is love of man there is love of the art. The goal of this friendship was human perfection through knowledge—the pursuit of perfection. In the case of nurses, woman healers, or midwives, however, it was the recognition of what was necessary and a relationship that prevailed through concrete affection toward specific individuals. This distinction dates back to antiquity and is expressed today in the daily attitude of physicians and nurses. This creates a difference in perceptions and judgment, behavior, and ethical reasoning. The physician has intellectual honesty, the nurse emotional truthfulness; that is why both professions are complementary and needed by each other.²⁵ The challenge is to get each profession to recognize their mutuality and need for collaboration in providing their respective services in the best interest of the patient.

Ethical dilemmas arise when miscommunication and controversy occur among patient, family, physician, nurse, and other healthcare professionals. When discussion and mutual decision making occur among those involved, there is less probability of ethical controversy becoming an issue. In spite of many independent functions, no one on the healthcare team functions independently of others in providing total healthcare to those being served.

Although there is no special brand of ethical reasoning or moral intuition "for nurses only," the continuing clarification of nursing's identity as a profession has significantly increased each nurse's ethical accountability in the realm of nursing practice. The developments in nursing research and knowledge in recent years have stimulated thoughtful reflection and debate on the philosophical basis of ethical judgment in the nursing profession. By virtue

of their pervasive presence in healthcare settings and the continuity of their care to individuals, families, and community groups, nurses may be more concerned with some ethical issues than with others. The goal of nursing actions is directed toward supporting and enhancing patient self-determination, which is

basic to respect for persons, and is demonstrated through advocacy. Multiple biopsychosocial factors must be considered in deciding the plan of care. In reality, this decision, certainly in most cultures, would involve multiple discussions with the patient and family and among members of the healthcare team.

ETHICAL DECISION MAKING

A review of the literature does not substantiate a significant difference in the decision-making processes nurses and physicians use in solving ethical problems. The real difference may be how each views the patient or client from a combination of his or her personal and professional perspectives. The trend is not to adhere to a particular ethical theory because this approach tends to embody only one point of view, may lead to an erroneous stereotypical solution, and is most likely impractical. The discipline of ethics has shifted from a focus on rights-based universal principles to a concern with how individual stories are embedded within particular communities. Today, most healthcare professionals employ a framework of ethical principles, rules, and judgments rather than whole ethical theories in analyzing ethical dilemmas. Although this approach considers the crucial principles, the issues that are summarized by the ethics principles have prominence along with the context of the dilemma and the preferences for action expressed by those involved. Strong principled reasons must underpin the duty, obligation, or point of view for an ethical dilemma to exist. Ethical analysis proceeds as clear reasons are given, principles enunciated, and outcomes considered. The ethical analysis of a dilemma consists of moral reasoning or a system of justification that offers a rationale for decision making and action.^{26(p41)}

Nurses in their moral reasoning, according to Garritson,²⁷ apply the principle of beneficence more frequently than the principles of autonomy and justice, and the beneficence/autonomy balance in their moral reasoning is parallel to the care/justice tension Gilligan²⁸ described. Cooper²⁹ found that nurses relied on both a principle-oriented framework (self-determination and nursing obligation) and a moral response of care involving attention to the details of patients' experiences. Peter and Gallop³⁰ also found that nursing students use care considerations more than justice considerations, but their moral orientation could best be described as mixed. When nursing students were compared with medical students, the differences seemed to relate to gender, not profession; that is, women were more likely than men to use care considerations in their

moral reasoning. Both genders and both nursing and medical students use a mixture of care and justice considerations.³⁰

Conscious decision making may be minimized by healthcare professionals who hold well-defined value systems used in value ranking and tested against standards of personal conscience, professional codes of ethics, and legal liability potential. Grundstein-Amando³¹ noted that each carries his or her own unique subjective views based on personal experiences that ultimately affect the final course of action. Nurses are typically motivated in their ethical behavior by the value of caring that encompasses responsiveness and sensitivity to the patient's wishes. Nurses listen and try to understand the patient. They will seek vivid indications of the patient's feelings, intentions, and interests, gaining knowledge through personal touch and concrete interaction with the patient. They will attempt to maintain and sustain a relationship that reflects the patient's own specific terms and contexts, not necessarily invoking any rules of justice and equality. They take into consideration love, compassion, and tenderness, which give value to human needs and human weaknesses.

In contrast, physicians tend to value patients' rights and the scientific approach that implies a major concern with disease and its cure. Physicians will talk with the patient and will try to understand the patient's broad perspectives and motivating forces attempting to establish a relationship best described as an interaction between two separate individuals who aim to resolve together an ethical problem. The information that generates the knowledge held by the physician may be considered impersonal and universal, based on established ideals of medical practice and patient rights. In summary, these two groups view the patient's best interests from different perspectives.³¹

The following example shows how the nurse arrived at a moral perspective that seemed to differ from that of the patient and physicians, based on subjective knowledge of the patient and objective knowledge of the course of his illness and long-term care needs. The patient, an 84-year-old retired infantry colonel, widowed and living alone, was transferred to a medical unit following a lengthy

stay in the intensive care unit. Although alert and oriented, he was very frail. The nurse got to know him well as he fought to regain independence, insisting everything be done to maximize his recovery, and resisting any discussion about the possible need for transfer to a nursing home in the near future. As his recovery stalled, it became obvious to the nurse that nursing home care would be needed and that this was unacceptable to the colonel. She approached the attending physician about reviewing resuscitation status with the patient, but he decisively deferred to the patient's previous request that everything be done to keep him alive. During the fourth week, the patient developed a severe infection and became gravely ill. The resident physicians on duty prescribed aggressive resuscitation with intravenous fluids and dopamine, followed by nasotracheal suctioning and urinary catheterization. The thought of performing cardiopulmonary resuscitation and intubating this patient was disturbing to the nurse as she did not think the patient wanted to be kept alive with machines and medications. After the initial crisis, she discussed her concerns with the residents, who responded that they wanted to hold off on the Do-Not-Resuscitate issue at present. Fearing time was running out, she again approached the attending physician. Together, at the bedside, they reviewed the situation and treatment options with the patient. The patient requested resuscitation short of ventilation. This request was honored and aggressive treatment con-

tinued; the patient died of respiratory arrest 36 hours later. Although in this situation the resident physicians were clinically correct in responding to the patient's initial request, the nurse believed that her knowledge of the patient and his course of illness called for reassessing and reaffirming his wishes. Therefore, she contacted the attending physician and obtained an acceptable outcome.³²

It often becomes necessary to strike an acceptable balance between the emphasis on autonomy and one's commitment to beneficence and nonmaleficence depending on the cultural context, specific situation, and the patient and healthcare professionals involved. It was not all that long ago that patients in our culture were often not told of a terminal diagnosis. The commitment to autonomy reflects a change in our ethical standards and healthcare expectations. Even now, when patients overwhelmed with information find themselves incapable of making a treatment choice or find the choices unsatisfactory, concern is expressed whether promoting autonomy may result in harm to the patient. In some cultures, healthcare professionals routinely do not disclose the diagnosis and prognosis to the patient in situations of terminal illness. Instead, the family is informed so they can ensure a social context of comfort for the patient. In this situation, healthcare professionals intend to protect the patients by relieving them of the burden of decision making, allowing them to feel secure and to gather their own resources for coping with their illness.

RESOLVING ETHICAL DILEMMAS

Clinical Interactions

Clinical ethics for nurses in the military versus those in the private sector, and for nurses in one of the military services versus another, do not really differ. Although it is true that military nurses may not always serve in locations of their choice, and the traditional practice settings of land, sea, or air, particularly during armed conflict, may be different for nursing in the Army, Navy, and Air Force, basic ethical decision making is not affected.

The overlay of wartime nursing does, however, add professional strain and certain moral dilemmas. Nurses are routinely exposed to the casualties of war. Casualties include their comrades, prisoners, detainees, and injured civilians (indigenous and displaced persons and refugees). Among the latter, women, children, and older persons are especially vulnerable. These nurses are confronted with great numbers of patients, many to survive with high

degrees of long-term disability, and some unavoidable deaths, over a prolonged period of time. Military nurses began to deal with triage and rapid evacuation, as we know it today, during World War II. These systems, improved during the Korean and Vietnam conflicts, have served as models for peacetime mass casualty care and trauma centers.

Vietnam nurse veterans reported several experiences that caused the most stress. They included: (a) treating patients who in many cases were younger than they, (b) encountering wounds more severe than they had previously seen, (c) dealing with patients who often put concerns about their buddies ahead of themselves, (d) evacuating a patient and losing touch with his case, (e) accepting a system of treatment—triage—that may have been based on expediency but violated every creed of accepted nursing practice (treating the less injured first), (f) and the deaths of those counted as friends. They also recounted being troubled by these dilem-

mas—sending recovered patients back into the field where they might be wounded again or killed (although the mission was to keep the combat units at fighting strength)—and working with physicians, nurses, and enlisted men who were prejudiced against the Vietnamese (although caring for wounded enemy and refugees was commonplace).¹ Prisoners and detainees are entitled to healthcare, humane treatment, and the right to refuse these offers and to die with dignity in a peaceful manner. Nurses are often the first to suspect or detect ill treatment of these persons and must take appropriate actions to safeguard their rights. This is an awesome responsibility.³³

The Vietnam conflict had a dramatic effect on the professional philosophy and career decisions of many nurses.¹ Of 50 veterans interviewed, 60% reported they returned home with a stronger commitment to the profession and felt they could do their jobs well and handle challenging situations. About half of the group changed their clinical work to another specialty or a different type of practice setting. The majority (72%) said they would volunteer for duty in a war zone today. The 12 on active duty remained close to their war experiences in other ways: Three Air Force nurses and one who was in the US Army in Vietnam fly on medical evacuation planes and use their expertise to train other nurses; several US Navy nurses helped design new hospital ships; and a number of US Army nurses used their experiences to train and plan future requirements for nurses in war situations.¹

In any clinical setting, weighing competing principles that support alternative courses of action is the essence of resolving ethical dilemmas. Clinical decisions are often approached from several perspectives including law, self-interest, professional codes and guidelines, clinical standards, and ethical principles. Striving to make right decisions and avoid making wrong ones is a common goal of healthcare professionals as they address the health and comfort of patients in their care. From the perspective of law, decisions must be consistent with legal rules to minimize the risk of prosecution and lawsuits. From the perspective of self-interest, decisions may advance the welfare of the professional or the institution, but they should not constrain moral action. Internal constraints include lack of professional confidence, fear, and insecurity. External constraints may include the authority of physicians, the policies and directives of hospital, medical, or nursing administration, or the threat of legal action. Many of these constraints, deeply rooted in history, are part of the socialization of the healthcare

professions and the organization of healthcare services. This influence has been considered to be so strong that nurses in some settings did not always feel free to be moral.³⁴

The military environment must be sensitive to the influence of relationships between superiors and subordinates, particularly as related to rank and position. In today's environment, relationships between powerful superiors and subordinates are often viewed as coercive even when there is no specific allegation of harassment. For professional nurses, being commissioned as officers somewhat levels the playing field; yet, position within their practice setting could be an issue. Appropriate use of the chain of command will resolve these instances should they occur. One such resolution is illustrated by the following quotation:

[T]here was [sic] five or six of them and me. And again, I'm a lieutenant, they all like way outrank me and...there wasn't [sic] any other nurses there either, it was just all docs and they were all...banding together against me. And that's when I said, okay, forget it, you know, if they're gonna [sic] pull this kind of communication style, I'm going to enlist the support of my chain of command, and pull them in.... Things went smoothly. Um, much more. It started unofficially with just Mr. Y there. One of the...surgeons, the vascular surgeon who's the chief though, so it was somebody who was actually was further up in the chain of things, and then the chief resident of the SICU [surgical intensive care unit] service, and my head nurse and I. So there was the six of us in the room together and communication was more professional and open.³⁵

To assure an environment where professional nurses bear primary responsibility and accountability for the nursing care patients receive, the *Army Medical Department Standards of Nursing Practice* was published in 1981. This comprehensive document referenced a symposium on bioethical issues in nursing and the ANA Code for Nurses. It was noted that "implementation of these standards will serve to enhance the cooperative and collaborative relationships of the health care team who seek to provide optimal health care to patients and their families."^{36(p1-1)}

As members of the healthcare team so integrally involved in patient care, and as part of their role as patient advocates, nurses should participate in ethical decision-making processes. Over the past 25 years, there has been a rapid increase in the number of institutional ethics committees in healthcare facilities and nursing participation in committee activities. Committees are now interdisciplinary,

having administrators, physicians, nurses, clergy, social workers, and attorneys represented. It is common to have members from other healthcare disciplines, patient representatives, quality improvement facilitators, ethics consultants or philosophers, and healthcare consumers of the institution represented as well. The more open the committee is to multidisciplinary participation, both as members and for consultation or referrals, the better the setting should be to address the ethical issues, questions, or dilemmas of staff and consumers.

The usefulness of the multidisciplinary approach to address ethical dilemmas is shown in the following case where caregivers held divergent views of what was in the best interest of the patient.

Case Study 20-1: Life Following Tragedy. A young soldier had suffered a severe wound caused by a grenade explosion; the severed spinal medulla led to an irreversible paralysis from the neck down. Excellent surgical and medical treatment kept the patient alive. When he became aware of his irreversible condition, the soldier begged to die. The doctors maintained him on parenteral nutrition while the nurses wanted to discuss the young man's future. The doctors' attitude was one of denial while the nurses' was one of oversensitivity toward the patient's demands. This led to underlying conflict between the doctors and nurses. Finally, the case was debated during a grand rounds session attended by representatives of the hospital ethics committee. This, by itself, reduced the anguish.

Comment: Abrupt tragedy, like the experience of this young soldier, not only affects the patient and significant others but also those providing his care. In the initial days following the event, the physicians focused on sustaining life while the nurses tended to focus on the meaning and quality of life. When each stepped back from the immediacy of the situation during grand rounds, their views could be presented and discussed, along with those held by others. After all, the healthcare disciplines are taught that rehabilitation begins with admission, and certainly in this case, there was much work to be done.

A survey of Army hospitals in 1986 confirmed that the prevalence of medical ethics programs paralleled that of the private sector.³⁷ Most respondents recognized the advisory or consultative role as being most useful. The educational, case review, and policy interpretation roles were viewed as beneficial but not to the same extent. A similar survey in the metropolitan New York area reported that all participating institutions included nurses as members of the hospital ethics committee.³⁸ Although most nurses held administrative and management positions, a few members were from clinical positions, particularly specialty areas such as critical

and emergency care. The topics most frequently addressed by ethics committees, in descending order, were Do-Not-Resuscitate, withhold-withdraw treatment, acquired immunodeficiency syndrome (AIDS), allocation of resources, patient rights, and death and dying. When asked to identify those issues "most important" in nursing practice, respondents reordered the same topics and added professional practice issues as second most important.³⁸

An ANA publication, *Ethical Dilemmas in Contemporary Nursing*, included chapters on similar issues.³⁹ Some of the topics were Do-Not-Resuscitate, advance management preferences, informed consent, the patient who refused to be fed, the issue of restraints, and care of the pediatric patient with AIDS. The practical ethical questions that may arise in the clinical management of patients frequently include scenarios related to these topics. How nurses, physicians, patients, families, and other members of the team approach resolution of these issues is important to all. Obviously, in many clinical situations more than one solution, right answer, or treatment option is possible. Culture, religious and political beliefs, and socioeconomic circumstances influence the final choices.

Considering the complexities of today's healthcare environment, influenced by rapid technological and scientific advances (genetic engineering, for example), multiple treatment alternatives, escalating costs, an aging population, and so forth, it is not unexpected that various healthcare professionals would hold differing opinions depending on their vantage point. If one assumes that the primary concern of these professionals is the well-being of the patient, then it is imperative for them to come together as a team to promote this goal. To resolve conflict and deal appropriately with ethical questions, recognition of each other's rightful authority, competencies, and value to the total care of the patient is essential. The greater the degree of collaboration between nurses and physicians caring for the patient and family, the easier it becomes to find resolution. Attributes of collaborative practice include mutual trust and respect, and shared decision making, responsibility, and accountability. Mutual trust and respect implies appreciation and understanding of each other's work, knowledge, and experience including the different views or perspective of a patient than the other may hold. Shared decision making requires understanding that professionals are interdependent and have a commitment to approach the negotiation process with an open mind.³⁰

Treatment options are expected to reflect com-

pliance with relevant professional codes and guidelines and should be based on appropriate clinical norms and standards. Decisions should also be consistent with general ethical principles. Decisions that seem right from one perspective, however, may not be right according to other perspectives and vice versa. Therefore, it is not feasible in some situations to clearly satisfy the best choice from all perspectives. Clinical data and ethical considerations must be weighed in considering the patient's best interests. Patients' particular preferences and values can be of great assistance in reaching the best decision. Patients are likely to be consistent and trustworthy advocates of their own interests as long as they maintain decision-making capacity. In the exceptional clinical situations when the healthcare team cannot resolve recalcitrant ethical conflicts among themselves or with the patient and family or both, consultation with institutional ethics committees or consultation services can be of great assistance with ethical dilemmas, just as consultation with specialists can help resolve difficult clinical questions.

Continuing Education

The increase in complexity of nursing practice has given rise to many ethical dilemmas. Nursing's commitment to patient care should always be directed toward supporting and enhancing the patient's self-determination because "health is not necessarily an end in itself, but is rather a means to a life that is meaningful"^{40(pi)} from the patient's perspective. The fundamental search for meaning in life can be viewed through observing the ethical and moral aspects of human actions. This is the case for the "why" and the "what for" of health and, therefore, associated with the medical act. We do not live to be healthy, instead we are or want to be healthy to live and work. However, it is worth raising the question, "Why do we live and work?" To reach and capture the sense of this meaning and to fulfill this role, nurses must be accountable advocates, although the patient is the primary decision maker in matters concerning personal health, treatment, and well-being.⁴⁰ Continuing education is required for nurses to maintain their competence and to enhance their professional advancement. It is an essential component of human resources development for nurses to support a high level of knowledge, skill, and commitment for the provision of quality care.

According to Smith,⁴¹ nurses need to recognize the ethical nature of their work, discern which ethical decisions are theirs to make, and acknowledge

their authority to make ethical decisions in their practice. To achieve this end, the Carruths⁴² concluded that continuing education might provide the most sound basis for the ongoing development and improvement of a practitioner's ethical conduct. The fundamental goals for continuing education in ethics are to increase understanding of ethically related issues, to increase awareness of other healthcare professionals' feelings regarding ethical issues, and to increase the ability to form ethical arguments and justify decisions. Taking it one step further, it is equally important to recognize, respect, and adopt a multidisciplinary approach to these decisions for the best interest of the patient. To be human, responsible, caring, and moral in the clinical setting is a burden shared by all.

Actually, Smith⁴¹ supported this approach in her discussion of deliberation and integration as two distinct components of the ethical decision-making process. Deliberation is the process an individual nurse uses to arrive at an ethical decision. Much has been published about nurses perceiving a lack of power or authority to make ethical decisions or act as free moral agents. Smith concluded that the problem is not significantly related to deliberation—how nurses consider their integrity, perspectives, consequences, and priorities, and arrive at a decision—but directly related to difficulty with the process of integration. Nurses have perceived a lack of power to effect the larger clinical ethical decision. Therefore an important goal of continuing education in ethics for nurses is to assist nurses in developing methodologies for participating as team members in the clinical ethical decisions made daily. The following quotation illustrates how a junior nurse in the military setting chose to deal with what she perceived to be an ethical dilemma regarding one of her patients:

I talked to the residents that were there in the room at the time, the SICU residents and the cardiologist happened to be on the ward as well and I just kind of said, "Look, did you guys like talk to the family, do you really think he understood what was going on?" And got a somewhat abrupt and rude reply, basically... "it's none of the family's business...of course he understood he signed his name." And I said...and I was like, "I don't think so," so I took it up a step further to the senior resident and it got even uglier. And so then I went up my chain and just talked to the nursing supervisor and my head nurse. My head nurse then said, "No...let's get everybody together and find out what the scoop is." And from there it went to a formal ethics consult, because the consent for surgery could easily be documented as illegal and unethical.³⁵

To enhance the process of developing team methodologies for attending to ethical issues at the Walter Reed Army Medical Center, Washington, DC, the bioethics education program, "Decisions Near the End of Life," was implemented in 1996. The goals of the program, developed jointly by the Education Development Center, Inc. and the Hastings Center, are to:

- increase and improve communication between providers and patients, and among providers caring for the same patient around difficult issues of medical ethics;
- identify resources to help institutions examine their policies and procedures, develop new ones as needed, and bring practice into line with current policy; and
- demonstrate appropriate roles and responsibilities for healthcare professionals fostering teamwork and conflict resolution.

Case studies are used to address the difficult questions and ethical dilemmas that arise in the use of life-sustaining treatment for critically and terminally ill adults. Participants include physicians, nurses, social workers, administrators, attorneys, and pastoral counselors as well as other healthcare providers. This example demonstrates one approach to continuing education in ethics, an important component of professional development.⁴³

Another approach is demonstrated at the Naval Medical Center, Portsmouth, Virginia. Every member of the multidisciplinary Medical Ethics Committee is obliged to complete an ethics-training course and to undertake a continuing program of self-education. Available educational materials include: (a) written information and workshops on clinical ethics, (b) direct involvement in mock and real consultations, and (c) skills in communication, group leadership, individual and group dynamics, mediation, self-awareness, and multicultural sensitivity.

The ethics training course covers the: (a) history, mission, and scope of ethics committees; (b) command instructions involving ethical issues; (c) legal concerns involving ethical considerations of clinical care; and (d) obligations, focusing on disclosure, assessment of capacity, the informed consent process, confidentiality, and truthfulness. This leads to clinical ethics issues such as refusal of treatment, foregoing life sustaining treatment, controversial reproductive choices, access and cost, death and dying, and diverse cultural and religious traditions affecting decision making. Due to the ex-

tensive education and training commitment, members appointed to the Medical Ethics Committee serve for the duration of their tour of duty at the Naval Medical Center, Portsmouth.⁴⁴

The US Air Force has several ongoing initiatives in education, administration, practice, and research that focus on the ethical dimensions of healthcare. This, along with the appointment of a consultant for nursing ethics by the Air Force Surgeon General, reflects the position of nurses as moral agents. In addition to facility-wide ethics education programs and processes designed for comprehensive management of ethical and moral concerns, there is discussion of the moral reasoning process, ethical considerations, and the development of cultural competence in preparation for deployment to humanitarian and peacekeeping operations. These operations, for all the military services, may be in response to human-induced (eg, armed conflict, environmental degradation, industrial accidents) or natural (flood, earthquake, volcano) disasters. An immediate response to care for victims may be required, so readiness related to disaster response and preparedness plans is essential.⁴⁵ Similarities and differences between the practice environments at home and in deployed settings are explored. The challenges confronted during previous deployments are transformed into "lessons learned," and the information is integrated into readiness training exercises. Innovations and efforts at Air Force healthcare facilities have included: (a) interdisciplinary ethics committees along with consultative services for patient care concerns; (b) improved communication processes to address ethical issues and to share information from both the academic and practice communities; and (c) classes, courses, and conferences to teach ethics and moral reasoning. Access to the Internet, Worldwide Web, and e-mail facilitates communication on ethical issues as well as the use of more traditional reference sources.⁴⁶

The Worldwide Web has the potential to be the best mode of delivery for ethics education. The Nursing Ethics Network (which can be accessed at www.bc.edu/nursing/ethics) has identified the need for ethics education and research resources as the two most frequent reasons nurses turn to their Internet ethics service. Nurses are asking for help with professional competence questions and complex care decisions with an ethical component and seeking resources for advancement of ethics within their work setting. Members of the advisory board with ethics expertise respond to the questions. They do not provide answers but assist nurses to find resolutions themselves.⁴⁷

Nursing Research

The 2001 “Code of Ethics for Nurses With Interpretive Statements” promotes nursing behaviors that contribute to the ongoing development of the profession’s body of knowledge. Therefore, nurse researchers investigate the many factors known to affect human health for the purpose of developing clinical interventions and providing information that will guide and improve nursing practice. The focus is to expand the body of knowledge related to the enhancement of personal health, to ameliorate pain and suffering, and to improve patient care in a manner that will restore individuals, or communities, or both to their highest level of functioning.⁴⁸

All nurses have a role in the research process, whether they are principal investigators, subjects, or merely consumers of research. It is the responsibility of every nurse to develop an awareness of nursing research, to use it in patient care, and to articulate it in patient/family education. In the clinical setting, nurses caring for patients who are research subjects serve as patient advocates, identifying potential ethi-

cal problems related to their participation in the research protocol. Nurses, at time of employment, should be informed regarding their expected roles as subjects or data collectors in research projects. Early publications by the ANA on the rights of persons who participate in research included the 1975 “Human Rights Guidelines for Nurses in Clinical and Other Research,” and the 1976 guidelines for the “Preparation of Nurses for Participation in and Utilization of Research.” More recently the association published, “Ethical Guidelines in the Conduct, Dissemination, and Implementation of Nursing Research.” This comprehensive document provides a detailed framework for ethical nursing research. The focus is on nine ethical principles with commentary and research guidelines for each principle⁴⁹ (Exhibit 20-2).

Although military nurses were highly instrumental in establishing nursing research in general, documentation of when and where military nurses first became involved in research is rather vague. However, Dr. Harriet Werley referenced articles describing Army nurses’ early work in relation to research in military situations:

EXHIBIT 20-2

ETHICAL PRINCIPLES IN THE CONDUCT, DISSEMINATION, AND IMPLEMENTATION OF NURSING RESEARCH

1. The investigator respects autonomous research participants’ capacity to consent to participate in research and to determine the degree and duration of that participation without negative consequences.
2. The investigator prevents harm, minimizes harm, and/or promotes good to all research participants, including vulnerable groups and others affected by the research.
3. The investigator respects the personhood of research participants, their families, and significant others, valuing their diversity.
4. The investigator ensures that the benefits and burdens of research are equitably distributed in the selection of research participants.
5. The investigator protects the privacy of research participants to the maximum degree possible.
6. The investigator ensures the ethical integrity of the research process by use of appropriate checks and balances throughout the conduct, dissemination, and implementation of the research.
7. The investigator reports suspected, alleged, or known incidents of scientific misconduct in research to appropriate institutional officials for investigation.
8. The investigator maintains competency in the subject matter and methodologies of his or her research, as well as in other professional and societal issues that affect nursing research and the public good.
9. The investigator involved in animal research maximizes the benefits of the research with the least possible harm or suffering to the animals.

Source: Silva M. *Ethical Guidelines in the Conduct, Dissemination, and Implementation of Nursing Research* (D-95 5M 5/95). Washington, DC: American Nurses Publishing; 1995: 4.

Clara Maass' participation in the yellow fever experiments in 1901, which resulted in her death; Sara E. McCallister's work and association with studies of wounds and infection; Claussen's patient categorization according to nursing care needs; Charlotte Rodeman's work with the milieu therapy study group; Mada F. Woodward's and Alice S. Clark's work on reducing bacterial count in hospital areas through hospital disinfection with beta-propiolactone; Phyllis J. Verhonick's research on decubiti; Mariam K. Ginsberg's research on oral and nasal hygiene; and Jacqueline H. Sellels and Ann E. Yodees study of temperature readings.^{50(p52)}

Werley also described the supporter, technician, consultant, collaborator, and investigator roles of nurses in research.⁵¹ The establishment of the Department of Nursing at Walter Reed Army Institute of Research, Washington, DC, in 1957 created an unprecedented and unique opportunity for US Army nurses. Nurse investigators, assigned to the unit and free of nursing service commitments, had the opportunity to assist and learn from accomplished investigators. These early pioneers were committed to the pursuit of research in nursing practice and viewed Walter Reed General Hospital, adjacent to the Institute, as a fertile clinical laboratory.⁵² From 1961 until 1969, seven classes totaling 28 nurses attended the 10-month-long Military Nursing Practice and Research Course. The unit continues today, now known as the Nursing Research Service, Department of Nursing, Walter Reed Army Medical Center. Current research projects, under the auspices of this unit, include significant participation in the Tri-Service Nursing Research Program.⁵³

Since the 1960s, the US Army Nurse Corps has provided graduate education in civilian university programs for selected, promising nurse researchers. Over time, the US Army designated a nursing research consultant to the Army surgeon general (1968), formed the Nursing Research Advisory Board (1976), established the biennial Phyllis J. Verhonick Nursing Research Symposium (1981), and implemented a regional approach to support nursing research. Much of the military nursing research literature is contained in theses, dissertations and studies from training programs, available only through the National Technical Information Service or the Defense Technical Information Service. The history of nursing research in the US Navy and US Air Force has been traced through the review of unpublished masters' theses and mimeographed documents from the School of Aerospace Medicine, Brooks Air Force Base, Texas. More formal nursing

research endeavors began in the US Air Force in the late 1960s and in the US Navy in the early 1980s.⁵⁴

The Tri-Service Nursing Research Program was established in fiscal year 1992 when Congress appropriated initial funding of \$1 million to support targeted research by military nurses. The purpose of the program is to improve nursing care for Department of Defense beneficiaries by expanding the body of scientific knowledge upon which military nursing practice is based. Research funded by this initiative should have a positive impact on healthcare and the health status of military populations. In 1993, the call for proposals identified ethics studies as one of the priorities for funding. Current studies with ethical implications, funded by the program, include: (a) Nurse-Patient Relationship Patterns: An Economic Resource; (b) Effects of Separation on Families During Hospitalizations; (c) The Lived Experience of Military Women Who Discontinued Breast Feeding Before Planned; (d) The Effects of Culturally Sensitive Messages and Health Beliefs; (e) Fatigue Following Childbirth: Military Family Outcomes; (f) The Experience of Chief Nurses in Military Operations Other Than War; (g) Neurometric Assessment of the Effects of Analgesia; and (h) Listening to Voices of Women in a Family Advocacy Program.⁵⁵

During its first 4 years, the Tri-Service Nursing Research Program developed a \$9.68 million portfolio of 77 projects conducted by nurses in the armed forces. Awards were granted to members of all three military services, including active, reserve, and guard components. "Military nursing research addresses many areas: the unique military environmental settings in which care is provided; mission readiness and deployment of military personnel; and improving nursing structure (delivery systems) and processes to enhance clinical outcomes, health status and quality of life of diverse military personnel, their beneficiaries, and populations receiving care during humanitarian, peacetime, and wartime missions."^{53(p17)} Findings from military nursing research not only benefit the military, but in many cases also benefit the private sector.

Nursing Administration

Ethical dilemmas in the practice of nursing administration differ from those in clinical nursing. Yet, obligations to patients, staff members, and the profession involve judgments about justice, fidelity, and beneficence. The resolution process remains much the same for most ethical dilemmas. Nurse administrators, as any organizational leader or ex-

ective, are morally obligated to use their influence and power responsibly to better serve their constituents. In various situations, nurse administrators may experience conflicting expectations and values. These may include doing good for one patient or employee versus benefiting all patients or employees; attending to the welfare of an individual or group within the organization versus responsibility to the institution or organization as a whole; and serving the moral obligations of administrative practice concurrently with those of professional nursing, including balancing costs and benefits. Nurse administrators strive to provide safe and respectful work environments with adequate support and resources where personnel provide quality care to meet patient needs.

Recent changes in healthcare reimbursement systems have caused administrators to focus on ethical issues related to the appropriate use of human and financial resources. Heightened competition for nursing resources both within and among countries, characterized by an increasing demand and a decreasing supply, has highlighted the importance of human resource planning and development at a global level. Although career mobility and multicultural practice are desirable, nurses must not be exploited as the result of unscrupulous recruitment or inappropriate working conditions. Fair and cost-effective recruitment and retention practices are an important component for assuring an adequate supply of qualified and committed nursing personnel.⁵⁶

Research has identified administrative decisions related to patient care issues as most likely to present ethical dilemmas. These included staffing level and mix situations, developing/maintaining standards of care (quality), and the allocation of scarce resources. Respondents also ranked those decisions related to patient care issues as highest in frequency of occurrence. Issues related to employee interpersonal or professional performance were reported less often as presenting ethical dilemmas. These included problems related to physician or nurse incompetence, demotion or termination of employees, and employee relations.⁵⁷

Most nurse administrators are challenged to provide more cost-effective care, a goal of the restructuring occurring in the American healthcare system. The aim is to reduce waste and costs, enhance efficiency and access, and pass on savings to the purchasers of healthcare without loss of quality. When nurses are concerned that work redesign would compromise the quality of care, Mahlmeister⁵⁸ recommended that the plan, action or activity be examined by asking three questions: (1) Is this legal? (2) Does this

violate an accepted or published standard? and (3) Will this violate the ANA Code of Ethics?

With thorough answers to these questions, efforts should be aimed at working at the lowest level possible in the system to resolve the issues in some mutually agreeable manner. If this is unsuccessful, top administration should be formally appraised of the situation. If the employer does not correct the problem, the nurse may need to move beyond the agency and report these concerns to appropriate authorities such as the state board of nursing. The ANA published the 1994 "Guidelines on Reporting Incompetent, Unethical or Illegal Practice" to assist nurses confronted with questionable actions or situations. This document describes these types of conduct and reporting responsibilities, and provides a model for action.⁵⁹

Nurses as patient advocates are expected to safeguard the client and the patient when healthcare and safety are affected by incompetent, unethical, or illegal practice by any person. Making the determination about what constitutes these behaviors is a first step; determining what to do about it is not always easy. Nurses frequently ask what they can do and whom they can tell about unsafe or illegal conditions that they are experiencing. They do not want, however, to experience discrimination or harassment or lose their jobs. Their concerns are well founded. If advocacy is the role of nursing, who protects the nurse in the advocacy role? Nurses must have the freedom to report unsafe practices without undue concern. Employing institutions and agencies providing nursing services have an obligation to establish a process for reporting and handling practices that jeopardize patient health or safety. The method may be as informal as an "open door" policy allowing staff members to take their complaints through all chains of command or as formal as a grievance and arbitration procedure. The point is that some established process needs to be in place for reporting questionable actions so that nurses can pursue such matters through official channels without fear of reprisal.

Protection from workplace violence, including physical violence, sexual harassment, and verbal abuse is also essential to assuring nurses' rights to personal dignity, integrity, and freedom from harm. Among health personnel, the nursing staff is most at risk. Many factors, such as the stress of sickness, coping with potentially life-threatening situations, interventions demanding close physical contact, shift work, demanding workloads, and attitudes about women may aggravate misbehavior. Adequate staffing levels, work methods that support

quality care, and fostering respectful treatment for all help create a respectful and safe work environment. Appropriate security measures, confidential grievance procedures, access to counseling services and legal aid for victims and perpetrators of violence, and support of nurses during reporting/compensation and claim procedures reflect a “zero tolerance” of violence.⁶⁰

Such processes are necessary to balance the mechanisms of control that permeate the healthcare environment. These controls range from formal power, associated with hierarchical supervision, standard operating procedures, codes of conduct, and accreditation requirements, to informal influences such as peer pressure and prevailing attitudes within the organization. Recognition of the influence or power exerted on patients, subordinates, and peers is particularly cogent in the military setting where the superior-subordinate relationship is overt.

Military nurse administrators, being both commissioned officers and professional nurses, bear a dual responsibility to develop and sustain the ethical climate. As officers and leaders, the authority over subordinates is greater than almost any other human relationship in our society. Care must be taken to use this authority only to fulfill responsibilities and not to exploit or degrade subordinates. It is important to reach out in the organization, encourage openness, listen to what subordinates have to say, and help them establish the moral strength to do what they believe is right. Subordinates must be encouraged to look at options for resolving issues and to consider the ethical implications of the situation.

Even in environments where such processes are in place, each nurse has a personal threshold for the burdens and sacrifices that will be tolerated, and, therefore, there may be considerable variability among nurses. Each has to examine the tension between obligation to the patient and to colleagues, to the institution where they practice, and to themselves. The resulting action may be reporting to superiors or licensing boards, using institutional mechanisms, or in severe cases “blowing the whistle” through disclosure to law enforcement agencies outside of the employer’s facilities.⁶¹ Responsible nurse administrators should assure that nurse employees are aware of current nursing standards, the “Code of Ethics for Nurses,” and laws governing nursing and practices. Although the ultimate accountability for professional practice lies with the individual nurse, nursing leadership should support and assist their staff in meeting these professional obligations. Through discussion and practice, nurses develop a shared ethical perspective on how to accomplish their basic purpose while following acceptable means and giving reasonable consideration to the value and dignity of all human life.

Nurse administrators, in either the military or the private sector, must consider questions about staffing levels, clinical competence, standards of care, and economic efficiency as part of their routine responsibilities while they address fairness, faithfulness to duty, and commitment to the organization. When deployed, working in austere, sometimes dangerous, and culturally sensitive environments adds another dimension to the challenges for military nurse administrators.

CONCLUSION

The development of military nursing in the United States was closely associated with nursing leaders from the private sector. Many challenges were influenced by the social status attributed to nursing and to women in general at that time. Following the Civil War, the strong emergence of women from home to larger societal purpose helped set the stage for nursing to emerge as a profession and for trained women nurses to be included in military organizations.

Early references to ethics in nursing centered around morals and manners. Social etiquette was emphasized as the first formal schools of nursing attempted to attract educated daughters from respectable middle class families. Following World War I as more trained nurses were available to the profession, ethics content began to shift. Definitions of nursing

ethics, as an extension of ethics, were published and discussed as part of the nursing curriculum.

Initially, The Nightingale Pledge gained significant recognition as the code for nursing in the United States. Organized nursing, however, proposed to establish a more formal code for the purpose of promoting ethical standards for professional conduct. Since its inception in 1926, the “Code of Ethics for Nurses” has periodically been revised to remain relevant to changes in the nursing and healthcare professions. The code serves to inform both the nurse and society of the profession’s expectations and requirements in ethical matters. Revisions to the code, considered to be a living document, reflect changes in nursing’s relationship to society and the societal concerns of the times.

Nursing, in general, tends toward the psycho-

logical and social meaning of life and death, health and illness concentrating on patient advocacy and care. The practice of medicine tends toward the disease-fighting model concentrating on the application of research and cure. Although there are distinct differences between the professions, no one on the healthcare team functions independently of others in providing total healthcare to those being served. The challenge is to get each to recognize their interdependence and to collaborate in providing the most beneficial treatment and care to the patient.

Acting in the best interest of the patient when addressing traditional ethical questions in healthcare and other underlying principles or values for patient care appears to be the same for all healthcare professionals. Even the decision-making processes nurses and physicians use in solving ethical issues do not appear to significantly differ. The real and important difference may be that each views the patient and any related ethical dilemma from a combination of his or her own personal and professional perspectives.

Although clinical ethics for nurses in the military do not differ from those in the private sector, the overlay of wartime nursing does add professional strain and certain moral dilemmas. Even though nurses feel pride in their contributions to patient care in austere and sometimes dangerous environments and the wartime role of professional nursing, their feelings and attitudes toward armed conflict may be forever tempered. The stress of the

experience impacts future perspectives.

Considering the complexities of today's healthcare environment, it is not unexpected that various providers would hold differing opinions depending on their vantage point. Ethical dilemmas arise when miscommunication and controversy occur among patient, family, physician, nurses, and other healthcare professions. The ultimate goal is to bring the individuals together as a team to resolve their issues in the best interest of the patient. The greater the degree of collaboration between nurses and physicians caring for the patient and family, the easier it becomes to find resolution. Collaboration includes mutual trust and respect, and shared decision making, responsibility, and accountability.

Continuing education to emphasize collaborative ethical decision making is an important component of professional development. Another is research to extend the body of professional knowledge and to improve practice. Adherence to ethical principles in the conduct of research and professional practice is essential. Incidents of incompetent, unethical, or illegal nursing practice must be reported to the appropriate authority. Nursing leaders are responsible for providing safe and supportive working environments that promote professional nursing practice and mutual respect. Military nurse administrators, as commissioned officers and professional nurses, bear a dual responsibility to develop and sustain the ethical climate. They must encourage subordinates to look at options for resolving issues and consider the ethical implications of the situation.

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