



CHAPTER 1

Nursing Ethics: Developing a Moral Compass for Leadership

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“Nurse leaders need to be the moral compass for nurses, using their power as a positive force to promote, provide and sustain quality practice environments for safe, competent, and ethical practice.” (Storch et al., 2002, p. 7)

NURSES HAVE THE RESPONSIBILITY TO ENSURE that their practice is not only technically and clinically competent, but also ethical. At the heart of ethical practice in any field is understanding what is happening, what ought to happen, and how to navigate the difference. Many of these responsibilities are articulated in professional codes of ethics, standards for nursing practice, and health care regulatory guidelines.

The focus of advanced practice nurse leaders on ethics in health care has not been consistently visible. For example, a leading

American nursing ethics scholar, Marsha Fowler, (2017) published a philosophical paper called “Why the History of Nursing Ethics Matters,” arguing for the importance of nursing’s unique ethical heritage, and the need for preservation of that history. With Fowler’s insights in mind, our premise throughout this chapter—and this book overall—is that for advanced practice nurse leaders, other nurses, and health care providers (HCPs), ethical action necessitates moving toward “the oughts” of ethical practice. This is true for ethical action that takes place for individuals, families, communities, and larger systems at local, provincial, and national levels.

A key element of ethics for advanced practice nurse leaders is social justice. Drawing on the work of Iris Marion Young (1990), social justice means understanding and addressing how members of communities experience oppression in different ways as a result of structural inequities. A multi-layered approach by nurses can avoid an otherwise narrow focus on individuals when socio-political contexts, such as poverty and immigration experiences, are ignored. Canadian nursing policy expert Michael Villeneuve (2017) warned that “politically, the [nursing] profession punches below its weight,” and that our “country is worse for it” (p. ix). Advanced practice nurse leaders in Canada are well positioned to increase their support for individuals, families, and communities; therefore, we have written this chapter to support the ethical practice of these nurse leaders.

Our intent in this chapter is to foster a relational understanding of persons, whereby we acknowledge that people are located in unique and multi-faceted socio-political and cultural contexts (Hartick, Doane & Varcoe, 2007). We adopt a relational understanding of social justice for nursing leaders as we consider moral philosophies of social justice and ethics of care. Leading Canadian ethicists describe a relational approach to ethics as including mutual respect, engagement, and embodied knowledge (Bergum & Dossetor, 2005). Relational ethics provides a means of attending to inequities experienced by people related to privilege and discrimination, which impair their health (Baylis et al., 2008). An ethical goal of nurses in advanced practice roles is to understand, and ultimately address, the cumulative effects of inequities at individual (micro), organizational (meso), and larger societal

(macro) levels, particularly for those who are marginalized, or who are at risk of being marginalized.

In what follows, we focus on ethical theory and practice in health care and nursing. In doing so, we provide a brief review of the history of health care ethics, relational ethics, and nursing ethics. We commence by summarizing the evolution of health care ethics. We then address the concomitant evolution of nursing ethics, including how nursing ethics is informed by a critical social justice perspective. This perspective includes *intraprofessional* and *inter-professional* practice and collaboration, ethical leadership, and relational practice. An exploration of related areas of ethical skill development for advanced practice nurse leaders—specifically in regard to ethical decision making—is included. This review is not meant to be exhaustive, as many theoretical perspectives are expanded and integrated in other chapters of this book.

In the latter part of this chapter, we include ethical decision-making frameworks and four case scenarios to assist readers to apply ethical analyses, develop their ethical decision-making and consultation skills, and generate related recommendations for action at the micro, meso, and macro levels of the health care system. We highlight the importance of promoting social justice for individuals, groups, and communities in the ongoing development and application of nursing ethics in Canada. By focusing on social justice, we join colleagues who have, over time, warned that inequities in access to appropriate resources lead to serious disparities in the lives of many people (Anderson et al., 2009; Clark & O'Mahony, 2021; Fraser, 1999, 2001; Young, 1990).

A Brief Overview of Health Care Ethics¹

For nurses and other HCPS to effectively engage in ethical practice that fosters the health and well-being of patients, families, and communities, they need to analyze and apply the beliefs and values that underpin their practice, including the values-based theories they use (Rodney et al., 2013). As Canadian ethicist Michael Yeo (2020a) reminds us, it is important for HCPS to appreciate and understand *ethics*, where the focus is on theories of right and wrong, and includes normative standards for conduct (Fry & Johnstone,

2008). It is also important for HCPS to appreciate and understand *morality*, where the focus is more specifically on the moral ideals of individuals and their judgments about what *ought* to happen in particular circumstances and contexts (Yeo, 2020b). HCPS enact morality in personal, societal, and group practice contexts (Doherty & Purtilo, 2016).

The study and application of ethics and morality have long and multi-faceted histories, which have been influenced over time by societal change and theoretical developments in philosophy and theology. HCPS have incorporated these developments into their practice to help determine their most appropriate moral actions in challenging clinical circumstances (Rodney et al., 2013). The application of ethical theory continues to help HCPS to “systematize moral intuitions, values, and principles in a consistent framework or to root them in a common ground” (Yeo, 2020b, p. 39). In so doing, such theory helps HCPS to enact what Yeo refers to as the “oughtness” of health care practice—that is, to consistently work towards values-based goals.

Some ethical theories that have particularly influenced the development of contemporary health care ethics include *deontology*—acting in a manner that universally focuses on the well-being of the individuals involved; *utilitarianism*—focusing on the practical effectiveness and consequences of actions and policies; and *contractarianism*—promoting fair distribution of goods and services, particularly for those who are in need (Rodney et al., 2013).

Other theoretical perspectives relevant to ethics include virtue theory, natural law, and human rights. *Virtue theory* was strongly influenced by philosopher Aristotle and theologian Thomas Aquinas. Virtue theory can assist HCPS to reflect on and enact virtues in living a moral life (Rodney et al., 2013). *Natural law* is an approach society has inherited from theology, and provides moral guidance in accordance with theological approaches to understanding and acting on rationality and nature (Rodney et al.). *Human rights* are often addressed in Western societal discourse and constrain powerful individuals from overriding certain interests of less powerful individuals. Legal theorists in particular are known for contributing to the articulation and actualization of human rights (Rodney et al.). Further, human rights are foundational to research ethics, where

there must be a significant focus on protecting the rights of patients and research subjects (Sherwin, 2011).

Notwithstanding the evolution in the development and application of ethical theory noted above, it is also important for nurses to pay attention to a caution from Fowler (2017), who suggested that the rapid and enthusiastic adoption of ethical theory from other disciplines risked overshadowing the moral identity of nurses. Fowler further warned that as nurses share ethical insights and progress with colleagues in other health care disciplines, they ought to be clear about the unique ethical history and identity of nursing. This history and identity entail a significant focus on social justice, including addressing oppression in society (Clark & O'Mahony, 2021). As authors of this chapter, we believe that advanced practice nurse leaders are well positioned to study, apply, and further develop ethical theory for nurses.

The Development of Nursing Ethics as a Field of Inquiry

As the field of health care ethics has evolved, so too has the field of nursing ethics. In what follows, we highlight the contributions of several of the early nurse theorists in ethics. We acknowledge that this is not an exhaustive review of all the contributors to the field of nursing ethics, in North America or worldwide.

One early contributor to the field of nursing ethics was Virginia Henderson, from the United States (US), who, in her groundbreaking 1966 book, *The Nature of Nursing: A Definition and Its Implications for Practice, Research and Education*, articulated that human needs were the central focus of nursing practice, and that nurses should care for patients until they could care for themselves. In her words, “patient care should be individualized ... the nurse will seek constantly to help the patient meet [their] needs and live as normally as possible” (p. 31). It is our belief that Henderson’s articulation of the nature of nursing helped to create an understanding of what nursing ethics ought to entail.

As nurse theorists continued to explore and write about nursing theory, it became clear that direction for ethical nursing practice was also required. In 1980, a Canadian pioneer in nursing ethics, Sister M.

Simone Roach, oversaw the development of the first code of ethics for registered nurses in Canada. Further, she developed an influential theory of caring, and wrote a pivotal book about this concept, *The Human Act of Caring: A Blueprint for the Health Professions* (1987).

In 1982, Janet Storch, one of the authors of this chapter, wrote a book entitled *Patients' Rights: Ethical and Legal Issues in Health Care and Nursing* (1982). This was one of the first books written by a nurse ethicist in Canada. In it, Storch described the role of nurses and other HCPs concerning patients' rights. She spelled out what the expectations should be for all nurses and people in care, based upon what were envisioned as consumer rights of the day; for example, the rights to be informed, to be respected, to participate in decision making, and to have equal access to care.

Another nurse scholar who led the way in developing nursing ethics was Sara T. Fry from the US. In the early days of nursing ethics as a field of study, she sought to differentiate nursing ethics from the rapidly evolving work in medical ethics and health care ethics, noting that the evolution of nursing ethics was initially too dependent on theories of medical ethics (1989). Fry built on the work of other nurse scholars who were addressing nursing ethics, and included perspectives from feminist theorists, such as Gilligan (1982) and Noddings (1984), as well as the perspectives of physician ethicist Pellegrino and philosopher Thomasma (1988). Fry argued that instead of relying solely on contemporary theories of medical ethics, the nursing profession ought to focus on caring as a core ethical value. In addition, she claimed that caring must be grounded by focusing on people rather than on abstract and idealized notions of moral actions. It is important to note that over time, Fry's theorizing about nursing has had a significant impact on the evolution of nursing ethics. She inspired nurses, including some of the authors of this chapter, to engage in scholarship regarding nursing ethics.

Another important contributor to the field of nursing ethics was Patricia Benner, from the US, who published a pivotal book titled *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (1990), where, based upon dialogue with nurses, she described how nurses acquire nursing knowledge, competence, and skill. Benner noted that too much attention had been given to role relationships and socialization in nursing practice and too little to

nursing ethics and actual nursing practice; that is, “the knowledge embedded in actual nursing practice, that accrues over time in the practice of an applied discipline” (p. 1).

Nursing research and scholarship related to nursing ethics have continued to evolve. In 1996, Verena Tschudin, a nurse from the United Kingdom, made a significant contribution to the nursing ethics world by founding the journal *Nursing Ethics: An International Journal for Health Care Professionals*.² Tschudin also published the books *Deciding Ethically: A Practical Approach to Nursing Challenges* (1994) and *Nurses Matter: Reclaiming our Professional Identity* (1999). In her 1994 book, Tschudin provided ten cases based upon a range of principles, such as truth-telling, justice or fairness, and honesty, demonstrating approaches to their ethical resolution. In her 1999 book, she explicated the link between ethics and power, and how power is used. She used the approach of outlining, then discussing, what should matter in ethical practice.

Another nurse ethicist from the UK, Ann Gallagher, has contributed greatly to the evolution of nursing ethics. She became editor-in-chief of *Nursing Ethics: An International Journal for Health Care Professionals*, following in the footsteps of Verena Tschudin. Her writing and scholarship in the field of nursing ethics are clearly articulated and influential. For example, she has written about the state of nursing ethics and the role of the International Council of Nurses, and she has also written a number of editorials related to moving the field of nursing ethics forward. In one editorial, she made a major contribution when she focused on providing care during the COVID-19 pandemic, and described the experience of families separated from their loved ones during the pandemic (Gallagher, 2021).

Marsha Fowler, from the US, is another leader in nursing ethics. She has published extensively about ethics in nursing, religion in nursing, health disparities, and health policy in global health. She has written several editions of an important book about nursing ethics titled *Ethical Dilemmas in Nursing Practice* with co-authors Anne Davis and Mila Aroskar (Davis et al., 2010). She also published a book about religious ethics and nursing with three co-authors, Sheryl Reimer-Kirkham, Richard Sawatsky, and Elizabeth Johnston Taylor (Fowler et al., 2012). Her leadership in

nursing ethics has included working with the American Nurses Association (ANA) to develop material such as a *Guide to the Code of Ethics for Nursing: With Interpretive Statements: Development, Interpretation, and Application* (Fowler, 2015a) and a *Guide to Nursing's Social Policy Statement: Understanding the Profession from Social Contract to Social Covenant* (Fowler, 2015b).

Writing by scholars about nursing ethics has proliferated, and nursing ethics texts, focused primarily on the education of undergraduate nursing students, have been developed. For example, in the US, authors such as Davis et al. (2010), Doherty and Purtilo (2016), and Fry and Johnstone (2008) have written textbooks that have been used widely. In Canada, Yeo et al. (2010, 2020c) have written a textbook that has been used extensively in undergraduate nursing programs. For graduate nursing students, Storch et al. (2004, 2013) developed and edited two previous editions of *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice*.

The development of nursing ethics has been enriched, as well, by colleagues in other professions. Nurse ethicist Vangie Bergum and physician ethicist John Dossetor wrote about relational ethics in their book titled *Relational Ethics: The Full Meaning of Respect* (2005). This book has had a significant impact on the evolution of relational approaches to ethics. Baylis (a philosopher), Kenny (a physician ethicist), and Sherwin (a philosopher) (Baylis et al., 2008) have individually and collectively written extensively about the theory and application of health care ethics. A particular focus of their collaborative work was on relational ethics, where they addressed ethical theory not just in abstract terms, but in terms of the relationships and power dynamics that constrain or foster individual and collective well-being.

As nursing scholarship about ethics, including the concept of caring, proliferated, thoughtful and constructive analyses of nursing ethics began to emerge. In 2004, nurse scholars Joan Liaschenko (from the US) and Elizabeth Peter (from Canada) co-wrote a paper discussing the limitations of contemporary understandings of nursing and nursing ethics, subsequently arguing for a conceptualization of nursing as work that profiles and analyzes the value of nursing's intellectual and manual labour. In continuing their focus on what nurses ought to do, and how, Liaschenko and Peter, as well as other

nurse scholars such as Storch et al. (2013), focused on nurses as *moral agents*; that is, as individuals who have the capacity to recognize, deliberate, reflect, and act on moral responsibilities. Peter offered a thoughtful analysis of how nurses could foster social justice by working through a socially connected model of moral agency:

Because social justice concerns primarily social groups and their relative positioning, as opposed to individuals outside of group membership, a conceptualization of moral agency as a social or collective construct is useful in terms of thinking about effecting social change. (2011, p. 13)

Peter's analysis is insightful and inspiring. Fabienne Peter (2004), a theorist from the United Kingdom writing on social justice, added the complementary insight that justice entails the premise that "to be able to pass a judgement on social inequalities in health, we need an understanding of the underlying causes" (p. 104). In other words, nurses ought to attend to the individuals they encounter in their practice, and pay attention to the wider relational contexts affecting those individuals. This broader view includes, for example, the familial, socio-political, and environmental strengths and challenges affecting all levels of context for individuals, families, and communities. A commitment to social justice is foundational to ethical nursing practice (Anderson et al., 2009), and is supported by a concomitant commitment to relational practice. Integral to these commitments is an understanding of human rights and social justice.

Nursing Ethics: Human Rights and Social Justice

Social justice is a concept that originated in philosophical discourse and is widely used across the social sciences and in ordinary language (Jost et al., 2010). The idea of social justice concerns a moral commitment to ensure that opportunities, resources, and privileges are fairly and equitably distributed between people within a society (Anderson et al., 2009; Cook et al., 2019). Nursing has a long history with roots in social justice work; in fact, the inclusion of broad social contexts and client-centred approaches

can be found across nursing's various communities of practice, from institutional to community settings (Clark et al., 2015).

At the heart of nursing's ethical commitment to social justice is the client, who is nested in a social and ecological environment. By considering social justice, nurses affirm a moral commitment to redress inequities and provide resources for health and health care access (Rodney et al., 2009). A growing body of research in nursing and the health sciences over the past decades has made it increasingly clear that social determinants of health have a major impact; yet social justice in nursing remains a work in progress (Anderson, 2009; Clark, 2015; Rodney et al.). For example, it is often unclear how codes of ethics can provide direction for nurses about social justice aims when they are making ethical decisions. Given the complexity of health care and structural vulnerabilities associated with systemic social exclusion, nurses need direction about social justice in order to foster a responsive health care system. This system should make space for nurses to take social action to help to redress systemic processes of exclusion directly affecting the health and well-being of communities and populations.

All nurses ought to have a mandate to enact their ethical commitment toward social justice. Advanced practice nurse leaders, including clinical nurse specialists and nurse practitioners, are in leadership roles where they are required to meet the complex health needs of Canadians in a wide variety of settings, and contribute to the development of a sustainable, efficient, and effective health care system (Canadian Nurses Association [CNA], 2017). From an advanced practice nursing perspective, the ethics of everyday practice is not devoid of social justice issues. Young (1990) has argued that oppression "is structural and occurs through systemic constraints on groups that are not necessarily the result of the intentions of a tyrant, rather ... its causes are embedded in unquestioned habits, norms and symbols, in the assumptions underlying institutional rules and the collective consequences of those rules" (p. 41). Thus, advanced practice nurse leaders are uniquely positioned to mitigate not only the inequalities and inequities that pertain to their clients, whether they be patients, families, groups, or communities, but also the policies which sustain and underpin the root causes of health and health care inequities. In this sense,

social justice can be viewed as an ethical imperative that is not apolitical. It can be defined as a normative practice of “political accountability” (Clark et al., 2015).

Diversity and Complexity

Our world is increasingly divisive, based on longstanding national and international inequalities. These inequalities include increased health disparities and social inequities at the intersections of race/ethnicity, class, gender, (dis)abilities, and sexual identities, as well as systemic processes of social exclusion, racism, and human rights abuses. The people who experience the most health disparities are the structurally vulnerable; that is, people who experience social exclusion and oppression based on, for example, racism and classism. Vulnerable groups also experience more complex care needs and multiple morbidities, such as chronic illness, mental health concerns, addictions, and issues of poverty and homelessness (Stafford et al., 2017; Stajdhuhar et al., 2019). These inequalities have become more apparent as a result of the impact of COVID-19 and the subsequent challenges of accessing and delivering health care. Historically, structural inequalities have excluded access by social groups to resources that support their health and well-being. With input from a variety of stakeholders, there is a growing move in Canada to address such inequalities. This includes continuing to engage in a truth and reconciliation process where nurses and other HCPs can be part of addressing the social injustices experienced by the Indigenous Peoples of Canada.

Equity

One of the goals of social justice is to work towards equity. By equity, we refer to the policies and practices which take into consideration the social determinants of health, so that people who are structurally vulnerable can access and receive appropriate care. Political feminist scholars Iris Marion Young (1990) and Nancy Fraser (1999, 2001) have drawn attention to expanding the notions of justice and equity. They argued for not only a (re)distribution of social goods and services, but also for social justice, including the recognition of difference and the systemic exclusion of non-dominant groups in

policy decision making. Fraser highlighted the need to recognize differences between social groups, which is fundamental to the notion of equity.

Jost and colleagues (2010) delineated three broad sets of criteria for social justice as a potential framework for consideration: (a) benefits and burdens in society are dispersed in accordance with some allocation principle (or set of principles); (b) procedures, norms, and rules that govern political and other forms of decision making preserve the basic rights, liberties, and entitlements of individuals and groups; and (c) human beings (and perhaps other species) are treated with dignity and respect, not only by authorities but also by other relevant social actors, including fellow citizens. In order to operationalize nursing leadership in advanced practice settings, a relational approach across micro, meso, and macro levels could strengthen a socially just health care system. As was noted earlier in this chapter, nursing practices across these levels intersect and are interrelated.

Values of equality can be seen in the distribution of benefits and burdens in society. However, Young (1990), Fraser (1999, 2001), and Reimer-Kirkham and Browne (2006) suggested that a broader framework for understanding social justice needs to extend beyond a distributive justice paradigm. This requires an analysis of the root causes of social inequities. Reimer-Kirkham and Browne stated that “with associated marginalization, one begins to see sustained intergenerational patterns of ill health and human suffering not as examples of poor individual choices or flawed social communities, but as the results of diminished life opportunities that have systematically ... been denied through complex institutional policies” (p. 335). The challenges with distribution policy are evident when examining access to primary health care services, which are intended to be the first point of contact to the health care system. Under an ideal distribution model, it is assumed that everyone can access health care despite, for example, their education level, language, health literacy, gender, and socio-economic status. However, many communities remain without access to primary health care, based on that complex array of circumstances. Thus, distribution of benefits and burdens must reflect the differences and differential impacts of

health experienced within society, particularly the systemic exclusion of non-dominant groups (Clark & O'Mahony, 2021).

Advanced practice nurse leaders ought to consider caring as a moral imperative. Care ethics, as a political and moral philosophy, can provide a lens to examine values and practices associated with social justice and advanced practice nursing. Engster (2014) argued that “care is the other half of health care that has been almost completely ignored in normative discussion of health policy but provides the best reason [...] to continue subsidizing comprehensive health-care services” (p. 156–157).

A focus on social justice should be taken up not only by individual nurses, but also by professional nursing associations. Indeed, the CNA (2017) highlighted that

Nursing ethics is concerned with how broad societal issues affect health and *well-being*. This means that nurses endeavour to maintain an awareness of aspects of social justice that affect the social determinants of health and well-being and to advocate for improvements. Although these elements are not part of nurses' regulated responsibilities, they are part of ethical practice and are important educational and motivational tools for all nurses. (p. 3, emphasis in original)

The ethics of everyday practice requires a relational and intersectional approach, in which the everyday is not devoid of social determinants of health, and therefore, engaging in political action, advocacy, and reflexivity is also a necessary component of nursing ethics. Given that ethics is an everyday practice, nurses ought to engage in political decision making and action to preserve the basic rights of society and health.

Health care is a human right, and lack of access to it needs to be seen as a serious form of injustice. The CNA (2017) has emphasized that nurses ought to use their individual agency to promote justice. However, this framing is not sufficient for contemporary nursing practice, and may not be useful to address the intersecting social and political dimensions of health and illness in a complex health care system (Pauly & Storch, 2013). In this context, it remains a

moral imperative that advanced practice nurse leaders and nurses across all settings engage in collective reflexivity and advocacy. The CNA (2017) stated that

Advocacy refers to the act of supporting or recommending a cause or course of action, undertaken on behalf of persons or issues. It relates to the need to improve systems and societal structures to create greater equity and better health for all. Nurses endeavour, individually and collectively, to advocate for and work toward eliminating *social inequities*.” (p. 5, emphasis added)

This means that taken-for-granted ideologies, such as historical, political, and social processes, must be problematized or critiqued to develop a socially just set of competencies. Thus, reflexivity and advocacy are used to deepen understanding, and also to promote action toward health care practices that foster socially just health care (Clark et al., 2015).

Promoting justice and fairness and the public good has too often been narrowly constructed through a justice lens, without full integration of *social* justice, which helps nurses to respect diversity regardless of characteristics such as age, mental or physical (dis)ability, race, gender, gender identity, gender expression, and sexual orientation, in order to uphold the dignity of all. In addition, social justice must also include respect for diverse ways of knowing, doing, and being. There is a need to decolonize ethics to consider respect, reciprocity, and relationality (Wilson, 2008). When nurses use relational approaches to social justice they move beyond mere recognition of difference to understand the impact of social connections on political and social policies, including policies in health care. Further, principles of respect should include acknowledgement of the impact of the social determinants of health on Indigenous Peoples, and moreover, must also include respect for relational ways of being and knowing. Decolonizing nursing ethics requires that nurse leaders develop and use a moral compass that includes these principles of respect.

In order to use such a moral compass, nurses need to have moral courage. Moral courage has been described by Indigenous scholars

as a concept originally developed within psychology to mitigate the impacts of colonization amongst Indigenous youth (Brendtro et al., 2019). Moral courage and relational ways of being can be used to promote ethical competencies and virtues for nurses. Advanced practice nurse leaders must be aware of the impacts of colonization on nursing practice and have the courage to change their practice when needed.

In continuing to examine social justice, it is important to consider some of the current ethical challenges in public health—for example, providing nursing care during a pandemic. As we noted at the outset of this chapter, Kenny et al. (2010) challenged a dominant individualistic ethics framework and summarized relational concepts that inform our re-visioning of public health ethics. Public health practitioners address the health needs of communities and populations through actions that are taken at social and political levels, which means there is a need to address the social nature of nursing practice.³ Justice, as defined within the 2017 CNA *Code of Ethics for Registered Nurses*, is about the rights of others, distribution of resources, and promoting the common good. However, relational social justice involves fair access to social goods such as rights, opportunities, power, and self-respect: “This view of social justice directs us to explore the context in which certain political and social policies and structures are created and maintained” (Kenny et al., 2010, p. 10). Drawing on the work of Powers and Faden (2006), Kenny et al. suggested that social justice is “the foundational moral justification for public health” (p. 10). We believe this foundation can help advanced practice nurse leaders to consider how different social groups are affected by a collective practice that creates and shapes inequalities in health access and opportunity.

Relational theorists have long argued that people are relational beings who exist in a web, and that relationships and networks are structured socially and politically (Sherwin & Stockdale, 2017). Advanced practice nurse leaders ought to be critically reflexive about how relationships are structured by systemic patterns of privilege or disadvantage. They ought not to ignore the ways in which various social and political groups (such as those organized based on gender, race, class, ability status, age, ethnicity, and sexuality) influence moral practices across the profession.

Young (2011) describes social justice as a collective responsibility. In the context of advanced practice nursing, this means that advanced practice nurse leaders have a shared responsibility to critique and ameliorate the social practices that result in unjust actions. They have the knowledge, skills, and ability to transform many structural processes so that health care access and outcomes are morally good and socially just. It is imperative that advanced practice nurse leaders consider dignity, respect, and relational approaches when promoting social justice.

A key moral mandate for nurses in ensuring that health care access is equitable and accessible to all is the *duty to provide care*. This mandate comes from the obligations and responsibilities of nurses to their clients, and is enshrined in the 2017 CNA *Code of Ethics for Registered Nurses*. Given this moral mandate, the editors of this book recognized a need during the COVID-19 pandemic to provide additional resources to assist nurses to make decisions about their duty to provide care. In the next section, we describe a resource that was developed by Storch, Starzomski, and Rodney to provide support for nurses as they engage in ethical practice (see Appendix 1-1).

Duty to Provide Care During the COVID-19 Pandemic

Nurses have a moral obligation to support the best interests of the individuals, families, and communities for whom they provide care—an obligation that has been particularly challenging during the COVID-19 pandemic. In the spring of 2020, when the pandemic was beginning, the British Columbia (BC) government embarked on the development of comprehensive documents to guide nurses and other HCPS in caring for people with COVID-19. Although the guidelines were carefully crafted, the editors of this book found that the guidelines did not fully address the complex, profound challenges that registered nurses faced at the frontlines of care. Following a review of the BC provincial documents, as well as related provincial and territorial guidelines and national resources, we developed a resource designed to address the gaps that we noted. Our proposed resource was structured in four quadrants for ease of

application, and our goal was to promote equitable and effective health care approaches (see Appendix 1-1).

The four quadrants we proposed focused on the following:

1. What is the nurse's duty to provide care?
2. How does a pandemic affect or alter the duty to provide care?
3. When is it acceptable for a nurse to withdraw from providing care, or refuse to provide care?
4. How should a nurse withdraw from providing care or refuse to provide care?⁴

Under quadrant one are items supporting the rationale for the duty to provide care, including the obligation of nurses to provide safe, competent, compassionate, and ethical care. This was founded on the ethical principle of beneficence—to benefit others. Nurses play an essential role in responding to a pandemic and in sustaining a functional and compassionate health care system.

Under quadrant two, where we outline how a pandemic affects and alters the duty to provide care, the reality of the risk of harm to nurses is highlighted, as well as the reality of a nurse's relational obligations. Also shown are the expectations nurses ought to have of their leaders, such as regular consultations about addressing risks and harms.

In quadrant three, we address the circumstances where it would be justified to withdraw from the provision of care, or refuse to provide care. Nurses have two notable and, at times, conflicting obligations. There is the obligation to provide care, but there is also the obligation to determine the circumstances under which refusing to provide care would be justified if the nurse was being placed at an unacceptable level of risk, such as when there was a lack of personal protective equipment (PPE).

In quadrant four, we provide steps to follow when a nurse judges that they need to refuse to provide care, or withdraw from providing care. These steps include speaking to health care leaders about the need to withdraw from providing care as soon as possible, and in time for alternate arrangements to be made. Reasons should be given for the planned withdrawal of care, with a willingness to weigh and consider new information.

Ethical Decision Making for Advanced Practice Nurse Leaders

Given the earlier discussion about theoretical underpinnings for nursing ethics, in this section we provide opportunities for advanced practice nurse leaders to consider theoretical approaches to develop ethical decision-making skills as they engage in nursing practice. To facilitate this development, we include (a) a guideline for duty to provide care (see Appendix 1-1); (b) two ethical decision-making frameworks (see Appendices 1-2 and 1-3); and four case scenarios. These resources are intended to assist readers to apply ethical analyses, and suggest recommendations for action.

The four scenarios below are composites of real-life situations that the authors of this chapter have been involved in over the course of their careers in nursing ethics. A number of key topics are illustrated in the scenarios, including the following:

- advanced practice nurse leadership
- listening to and valuing diverse perspectives
- relational practice
- a critical social justice perspective
- the duty to provide care
- interprofessional collaboration, and
- duties and responsibilities of individuals, teams, and organizations.

We leave it to readers to consider and address the Reflective Questions we have provided after each scenario. We recommend that, if possible, these scenarios and questions be discussed in collaboration with colleagues in order to promote intraprofessional and interprofessional ethical dialogue.

We begin with the following Ethics in Practice scenario, where we describe the leadership challenges surrounding duty to provide care faced by a clinical nurse specialist during the COVID-19 pandemic.

ETHICS IN PRACTICE 1-1*Duty to Provide Care During the COVID-19 Pandemic*

Marcie is a clinical nurse specialist, and also a new mother, who has just returned from maternity leave to her position at a long-term care facility. The facility is privately owned, and, prior to the COVID-19 pandemic, Marcie enjoyed her work with long-term care clients. She also appreciated the work of the diverse HCPs she worked with, including registered nurses, care aides, occupational therapists, physicians, and physiotherapists.

However, on her first workday back, Marcie realizes that the pandemic has been devastating for the facility, and that her staff colleagues are experiencing significant moral distress because of their difficulties meeting their clients' needs. Marcie becomes acutely aware of the shortage of PPE, and the effect that this deficit has had on her colleagues, who are often working short-staffed. The stories being told to her about the many residents who died alone are sad in themselves, but learning about the lack of staff to even hold a dying person's hand is heartbreaking. When she proceeds to follow up on the reasons for the facility being short-staffed, she finds that an absence of effective staffing guidelines, fear, and a lack of PPE seem to be key causal factors.

Marcie raises her concerns with the nurse manager in the facility, urging him to assess the situation and develop solutions for better and safer care, both now and in the future. The manager considers Marcie's request and asks her for help, as he has been overwhelmed with all the issues facing the facility as a result of the pandemic.

Although Marcie knows that being a nurse comes with a duty to provide care, she believes that more guidance is needed about the limits of that duty, and that senior managers and health authorities have a corresponding duty to secure adequate health care funding. Fortunately, Marcie remembers accessing guidelines developed during the COVID-19 pandemic which address four applicable matters: (1) nurses' duty to provide care; (2) how that duty might be altered by negative circumstances; (3) when it would be acceptable to refuse to provide care; and (4) how a nurse might refuse to provide care or withdraw from care.

Marcie subsequently reflects on how she and other HCPs could work together, and with senior leaders in the care facility, to influence positive change. Marcie has already taken on significant leadership in considering the staff's concerns but is struggling to determine her next steps.

REFLECTIVE QUESTIONS

1. *How might Marcie collaborate with colleagues to develop a plan to approach management regarding their concerns?*

2. *Why is it important for Marcie to recruit a diverse group of colleagues to join her in approaching management?*
3. *How could using an ethical decision-making framework and the duty to provide care guidelines (see Appendices 1-1, and 1-2, and 1-3) help Marcie to enact her leadership as an advanced practice nurse in this situation?*
4. *Reflect on the collaboration and ethical actions you have analyzed above. What are some implications for advanced practice nurse leaders, as well as other HCPS, in terms of their leadership and interprofessional collaboration?*

In the following Ethics in Practice scenario, we explore the ethically challenging context of treatment withdrawal when the patient no longer wants to proceed with treatment, but the health care team and the patient's family believe that there may still be hope for life.

ETHICS IN PRACTICE 1-2

Treatment Options in a Complex Critical Care Case

Abdul, a 56-year-old man who immigrated with his family to Canada five months ago, was admitted to Mercy Hospital, a large quaternary care teaching hospital, after suffering a major myocardial infarction (MI) at his home. Abdul's adult son, Imran, was with him at the time, and called an ambulance. Although Abdul promptly received oxygen and cardiac medications from the paramedics who arrived at his home, and was admitted to an acute care hospital within an hour of his MI, the damage to his heart was such that he required immediate critical care interventions, including mechanical ventilation, to survive.

Because of the extensive blockages in his coronary arteries, Abdul has been booked for emergency open heart cardiac surgery later that day to attempt to revascularize his heart. He is unable to consent to the surgery, as he is unconscious. However, it appears that Abdul would not want the cardiac surgery. When the cardiac surgeon arrives to assess Abdul, Imran tells the cardiac surgeon that his father told him, while he was having his heart attack, that he did not want to be saved if he would not be able to "come back as himself," and that he did not want to be a burden to his family.

If Abdul does recover, he will be facing an extensive program of cardiac and neurological rehabilitation. Because he is intubated for ventilation, and unconscious, Abdul is unable to communicate with the surgeon. Imran is named as Abdul's

substitute decision-maker, and has told the surgeon what his father said during his MI. The health care team, including the clinical nurse specialist, Melissa Tang, realizes that the ethics of Abdul's situation are complex, and she calls Ethics Services to request an ethics consultation.

While Melissa and the health care team are waiting for the ethics consultant to come to the unit, Abdul's wife, Salma, and oldest daughter, Nassim, arrive at his bedside. Open heart surgery is a procedure that Abdul and his family are not familiar with, and his family is frightened, particularly because they cannot communicate with him. When the family hears about the potential complications of the surgery and the extent of the post-operative recovery that Abdul would have to undergo, they are concerned. English is not their first language, and as they listen to what they are being told, they have little time to process what they are hearing. They are frightened, bewildered, and grieving.

Yasmin Farahani, a nurse ethicist, arrives in Abdul's room about 30 minutes after his family members. She has been informed about escalating staff concerns regarding how best to support Abdul and his family during the crisis they are experiencing. Yasmin asks Abdul's family for permission to spend some time with them to listen to their questions and concerns, and also offers to find an interpreter to assist with their conversation. She explains that she is the hospital's ethics consultant, and is available to explore and respect Abdul's previously stated wishes, consider his best interests, listen to and respond to his family's concerns, and to support hospital staff in caring for him.

Given the complexity of Abdul's situation, and the concerns of his family and the staff, the use of an ethical decision-making framework can provide guidance to explore the questions below.

REFLECTIVE QUESTIONS

1. *What steps could Yasmin take to set up an effective team meeting for Abdul's family?*
2. *Why is Yasmin's offer of an interpreter important in this situation?*
3. *How can the team ensure that Abdul's spiritual beliefs and ethnocultural values are being considered as they develop a plan of care?*
4. *How can Yasmin and Melissa support the health care team and Abdul's family as they engage in an ethical decision-making process that is focused on Abdul's prior wishes and his best interests?*
5. *How can Melissa, as an advanced practice nurse leader, foster dialogue among the ethics consultant, HCPS in the critical care area, and Abdul's family members?*
6. *How could Melissa and the team best prepare Abdul's family for the uncertainty of his prognosis, including his potential death?*

In the next Ethics in Practice scenario, we address a complex home care situation in an isolated Indigenous community. The community has limited available health care resources, presenting significant challenges to the patient, her daughter, HCPs, and the overall community.

ETHICS IN PRACTICE 1-3

A Home Care Challenge in an Indigenous Community

Sarah is a widowed 68-year-old Indigenous woman who has had mild dementia for the past four years. She lives in a small home with her 46-year-old daughter, in a rural community of Indigenous people in northern Alberta. The community members support one another, and access the nursing station for their health care needs when required.

Sarah and her daughter, Daanis, have few transportation options and limited access to regional health care resources in Alberta or nearby Saskatchewan. The nursing station in their community is staffed by four nurse practitioners who provide regular access to primary health care in the community, but there are no specialized long-term care resources. One of the nurse practitioners, James, sees Sarah regularly in the nursing station clinic. Sarah has told her daughter that she trusts James and hopes that he can continue to look after her.

Sarah has limited financial resources. Further, she is at the stage where, in order to remain at home, she needs more home care than can be provided by her family, the nurse practitioners, or other community members. However, Sarah has consistently expressed that her preference is to remain “on her land,” close to her daughter, rather than being sent to a long-term care facility outside of her community where the people and the land will be strange to her.

REFLECTIVE QUESTIONS

1. *As an advanced practice nurse leader in Sarah's community, how might James be able to support her autonomy and her well-being?*
2. *What key information does James need about Sarah and her family situation to help him identify key priorities in her care?*
3. *Why it is important for James to build collaborative and trust-based relationships with Sarah and other Indigenous people in the community?*
4. *How can James promote the development of trust between HCPs outside of Sarah's community and Sarah and her family?*

In the last scenario of this chapter, we present an ethically complex case of a refugee who requires end stage renal failure treatment immediately upon arrival in Canada. As the health care team strives for a positive patient outcome, resource allocation questions are raised and different layers of government policies and guidelines are considered.

ETHICS IN PRACTICE 1-4

Care for a Refugee Claimant with Kidney Failure

Fatima is 27-year-old lesbian who uses she/her pronouns. She left Iran after being persecuted because of her sexual orientation, and has been living in a refugee camp in Africa for the past two years. This year, a church in BC sponsored Fatima to come to Canada. After all her struggles, she is overjoyed with the prospect of living a better life in BC. However, on her trip to Canada, Fatima collapses in her seat as the plane is landing and is immediately taken to an emergency department (ER) near the airport. In the ER, it is determined that Fatima is in end-stage kidney failure and needs immediate dialysis. With the help of an interpreter, Fatima consents to begin dialysis and is transferred to a hospital with hemodialysis capacity.

After several months of hemodialysis, Fatima's condition improves somewhat; however, she is unable to seek work because of her dialysis schedule and overwhelming fatigue. She now worries about whether she will be able to remain in Canada, as the church is only sponsoring her for one year, until she is able to get herself established.

Colette, a nurse practitioner in the nephrology/transplant program, has organized a team meeting, with Fatima in attendance, to discuss a long-term plan of care. In the meeting, Fatima says that her sister, who still lives in Iran, has volunteered to donate a kidney. The program manager expresses concern about this. He states that having Fatima's sister assessed as a potential kidney donor in Iran, and then having her come to Canada for the donation if she is suitable, is fraught with complexity because of all the red tape and uncertainty about who would pay for all the costs that need to be incurred. In the meantime, until Fatima's refugee claim has been sorted out, she will need to remain on dialysis, and will not be placed on the deceased donor transplant waiting list.

Fatima is stressed and feeling despondent about her future. She asks to speak with Colette after the meeting. Fatima states that her dream of living safely and peacefully in Canada looks out of reach, and that she does not see a future for herself. She tearfully asks for Colette's help.

REFLECTIVE QUESTIONS

1. *How should Colette respond to Fatima's request? What is Colette's role in helping Fatima plan for her future in Canada?*
2. *What values should be considered in planning for Fatima's care?*
3. *What aspects of social justice should be taken into account in Fatima's case?*
4. *Who should Colette involve in future discussions about Fatima's care?*
5. *What resources might Colette use to help her to provide the care that Fatima requires?*

Conclusion

The development and use of ethical theory in nursing has a rich history which continues to evolve. As we have described in this chapter, this evolution requires nurses to focus on a number of areas, including relational practice and social justice. A broad notion of social justice is necessary for nurses to enact their responsibilities and obligations to address the ethical issues they face in their practice, as well as to be part of resolving complex societal ethical concerns. In order for nurses to do so, effective ethical decision making grounded in nursing ethics is key. The case scenarios in this chapter provide an opportunity for nurses, advanced practice nurse leaders, and other HCPs to use ethical theory and decision-making frameworks to resolve ethical challenges.

As authors of this chapter, we believe that a focus on a socially connected model of moral agency has had, and will continue to have, significant benefits for nurses in practice, especially advanced practice nurse leaders. As our lead-in quote for this chapter indicates, and through our shared research and study over many years, we have come to understand the value of advanced practice nurse leaders as moral compasses within practice settings. We continue to be interested in learning more about *how* to promote quality practice environments for safe, competent, and ethical practice. Fostering proactive communication and trust within and among HCP groups,

and across all levels of health care organizational hierarchies, is foundational to supporting all practicing nurses.

What this means to us now is that *all of us* in nursing—student nurses, nurse educators, nurses in practice, advanced practice nurses, and nurses in formal health care leadership roles—whether in practice, education, research, or health care planning and delivery—should see ourselves as moral agents charged with the collaborative leadership responsibility of guiding ourselves and others. As we move toward understanding what *is* happening, what *ought* to happen, and *how* to navigate the difference, we need to cultivate wisdom, courage, and humility. We believe that cultivating these three qualities will help all of us, as nurses, to provide and promote ethical nursing practice now and in the future.

QUESTIONS FOR REFLECTION

1. *In considering your own values and beliefs, how do you think they influence your approach to ethical concerns/issues/dilemmas? What are the implications for you as a moral agent?*
2. *How might you initiate discussions about ethics among health team members?*
3. *What actions can you take to foster a social justice perspective in your health care setting?*
4. *What actions can individual advanced practice nurse leaders take to strengthen their autonomy as moral agents? As members of organizations? In professional groups?*
5. *How might advanced practice nurse leaders work with HCPs, governments, and other organizations to decrease moral distress and foster moral resilience in health care settings?*
6. *How can relational values be fostered in health care organizations so that nurses and other HCPs are better supported in enacting a relational ethic?*
7. *What are some key initiatives that nurse educators could promote to foster ethical practice across diverse groups of health care providers?*
8. *How can advanced practice nurse leaders model ethical practice within and across diverse health care groups?*

Endnotes

- 1 In this chapter, we draw on content from: Rodney, P., Burgess, M., Phillips, J. C., McPherson, G., & Brown, Helen. (2013). Our theoretical landscape: A brief history of health care ethics. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 59–83). Pearson.
- 2 Its office was previously located at the University of Surrey, but moved to the University of Exeter with Ann Gallagher as Editor-in-Chief. Many Canadian nurses have served on the editorial board; many more have published within the journal.
- 3 For further discussion about public health ethics, see Chapter 4.
- 4 For more information about the duty to provide care and conscientious objection, please see the British Columbia College of Nurses & Midwives (n.d.) *Duty to Provide Care* and the CNA (2017) *Code of Ethics for Registered Nurses*.

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APPENDIX 1-1

The Ethical Duty of Nurses to Provide Care During a Pandemic*

**Janet L. Storch, Rosalie Starzomski,
and Patricia Rodney**

1. What is the nurse's duty to provide care?

The duty to provide care is foundational to nursing practice.

The duty to provide care is the obligation of nurses to provide safe, competent, compassionate, and ethical care.

This duty arises from the ethical principle of beneficence, which means to benefit others.

Nurses play an essential role in responding to a pandemic and in sustaining a functional and compassionate health care system.

3. When is it acceptable for a nurse to withdraw from providing care, or refuse to provide care?

Each nurse must first weigh the evidence about the risks involved in providing care, or continuing to provide care.

Each nurse must justify whether the expectations placed on them is unreasonable, taking into account the tasks they are being asked to do, mitigation strategies (such as appropriate personal protective equipment) that is provided, and their personal circumstances.

Nurses can withdraw from providing care, or refuse to provide care, if they believe that providing care would place them and/or others at an unacceptable level of risk, such as when there is a lack of personal protective equipment (gowns, masks, gloves).

Please refer to Endnote #4 in this chapter for more information about reasons for a nurse withdrawing from providing care.

2. How does a pandemic affect or alter the duty to provide care?

The risk of harm to a nurse can be serious or potentially life-threatening.

Nurses must consider their risks and take all measures to avoid serious harms.

Nurses must also consider their personal relational obligations, such as parenting duties and other caregiving commitments.

Nurses should expect their leaders to engage in regular consultations with them to prevent and address harms in practice areas and to consider risks to persons in their care.

Proactive and regular debriefing and support services ought to be provided for nurses and health care leaders to sustain their ability to provide care.

4. How should a nurse withdraw from providing care or refuse to provide care?

The nurse should speak to their leader about their need to refuse to provide care or withdraw from care.

The nurse's decision should be made known, as soon as possible, in time for alternate arrangements to be made. Risks to the person(s) in care must be considered.

Reasons should be given for the planned withdrawal of care, with a willingness to discuss and consider improved personal protective equipment and/or a different assignment, if possible.

The nurse must then weigh and consider any new information received from the leader to determine if their decision to refuse to provide care, or withdraw from providing care, would change.

* Please also refer to your own organization's guidelines about duty to provide care, as well as provincial/territorial nursing standards of care.

APPENDIX 1-2

Storch Model for Ethical Decision Making: Guiding Questions for Clinical Decision Making

Janet L. Storch

1. INFORMATION AND IDENTIFICATION

- Talk with all parties involved. From that conversation, there should emerge a central story.
- Learn about the patient's medical status and the expectations they or their family have for outcomes, as well as the expectations of the health care team.
- Gather non-medical information about social conditions, family roles and relationships, quality of life, and power dynamics in the situation.
- Determine level of competency/capacity.

2. CLARIFICATION AND EVALUATION

Consider the *values* involved:

- What is the significance of the values involved—oral, religious, cultural, personal, professional?
- What is the significance of these values to the people involved?
- What is the story behind the value conflicts?
- Consider the *ethical principles* involved:
- Which principles might be most important in this situation?
- Are some principles in conflict with others?

Consider the *social expectations* and the *legal requirements* involved:

- Is there any institutional history on a similar situation?
- What institutional policy requirements are important?
- What legal provisions need to be considered?

Determine a *range of potential actions* and their *consequences*:

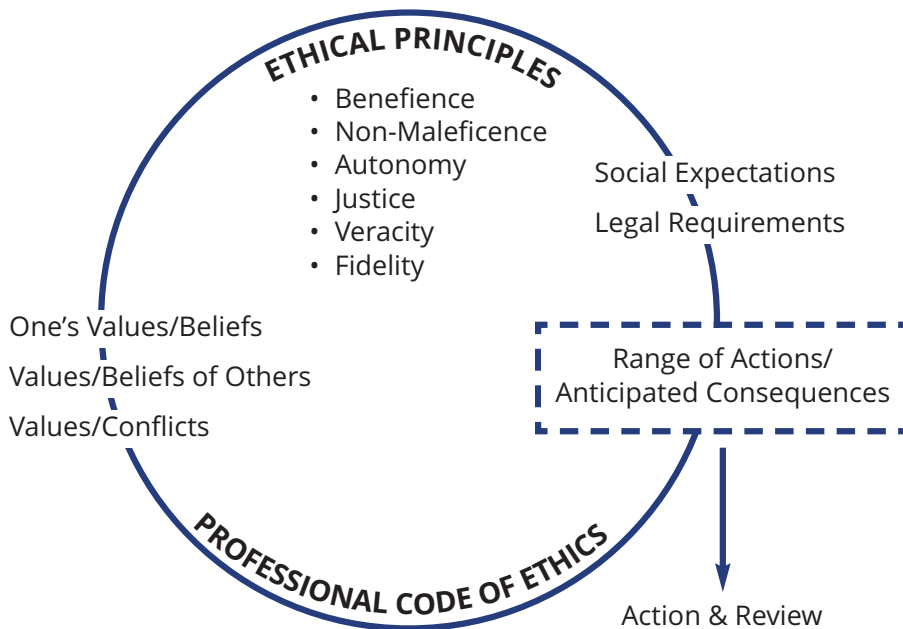
- Focus on ethically acceptable courses of action.
- Build consensus around which action is most fitting for the situation.

- Ensure patient, family, and team have common understandings about the plan of action.
- Plan to meet again to consider consequences/learning.

3. ACTION AND REVIEW

FIGURE 1-2-1

Storch Model for Ethical Decision Making



APPENDIX 1-3

An Ethical Decision-Making Framework for Individuals

**Michael McDonald (adapted by
Rosalie Starzomski and Patricia Rodney)**

1. COLLECT INFORMATION AND IDENTIFY THE PROBLEM(S)

- a. Identify what you know and what you do not know, but need to know. Be prepared to add/update your information *throughout* the decision-making process.
- b. Gather as much information as possible on the patient's physical, psychological, social, cultural, and spiritual status, including changes over time. Seek input from the patient, as well as the patient's family, friends, and other health care team members.
- c. Investigate the patient's assessment of their own quality of life and their wishes about the treatment/care decision(s) at hand. This includes determining the patient's decision-making capacity, as well as determining which family member(s) the patient wants involved in discussions and decision making about their treatment/care. If the patient does not have decision-making capacity, look for an advance directive. Identify a substitute decision maker for a patient who does not have decision-making capacity and seek evidence of the patient's prior expressed wishes. Regardless of the patient's decision-making capacity, involve the patient as much as possible in all decisions affecting them.
- d. Include a family assessment: What are the various roles, relationships, and relevant "stories"?
- e. Consider implications for social justice. Identify areas where patient and family resources for health and health care may be compromised.
- f. Identify the health care team members involved, and circumstances affecting them.

- g. Summarize the situation briefly, but with all the relevant facts and circumstances. Try to get a sense of the patient's overall health and illness trajectory. Determine what is most important to the patient at this stage of their illness and what their wishes are for the future.
- h. What decisions have to be made? By whom?

2. SPECIFY FEASIBLE ALTERNATIVES FOR TREATMENT AND CARE

- a. Use your clinical expertise to identify a wide range and scope of alternatives. Avoid binary thinking (such as treat/do not treat) and lay out carefully tailored alternatives for the problems you have identified.
- b. Identify how various alternatives might be implemented (for example, limited time trials of treatments).

3. USE YOUR ETHICS RESOURCES TO EVALUATE ALTERNATIVES

Principles/Concepts

Autonomy: What does the patient want? How well has the patient been informed and/or supported? What explicit or implicit promises have been made to the patient?

Nonmaleficence: Will this harm the patient? Others?

Beneficence: Will this benefit the patient? Others?

Justice: Consider the interests of all those (including the patient) who have to be taken into account. Are biases about the patient or family affecting your decision making? Treat like situations alike.

Fidelity: Are you fostering trust in patient/family/team relationships?

Care: Will the patient and family be supported as they deal with loss, grief, and/or uncertainty? What about any moral distress of team members? What principles of palliative care can be incorporated into the alternatives?

Relational Autonomy: What relationships and social structures are affecting the various individuals involved in the situation? How can these relationships and social structures be used?

Standards

Examine professional norms, standards and codes, legal precedents, health care agency policy.

Personal judgments and experiences

Consider your personal judgments and experiences, and those of your colleagues, as well as other members of the health care team.

Organized procedures for ethical consultation

Draw on the expertise of other health care providers as needed, and use the ethics resources available in the health care agency. Consider formal case conferences, an ethics committee meeting, and/or inviting an ethics consultant to provide assistance, especially if the situation is complex and/or conflicted.

4. PROPOSE AND TEST POSSIBLE RESOLUTIONS

- a. Select the best alternative(s), all things considered.

- b. Perform a sensitivity analysis. Consider your choice(s) critically: Which factors would have to change to get you to alter your decision(s)? Further, carefully consider whether you want to maintain or change your previous choice(s).
- c. Think about the effects of your choice(s) upon the choices of others. Are you making it easier for others (health care providers, patients and their families, etc.) to act ethically?
- d. Is this what a compassionate health care provider would do in a caring environment?
- e. Formulate your choice(s) as a general maxim for all similar situations. Think of situations where it does not apply. Consider situations where it does apply.
- f. Are you and the other decision makers still comfortable with your choice(s)? *If you do not have consensus, revisit the process.* Remember that you are not aiming at the perfect choice, but the best possible choice. If no consensus is forthcoming, is it possible to reach a compromise?
- g. Ensure that there is a clear implementation plan. Ensure that the rationale and details of the plan are clearly communicated to all those who will be affected (patient, family, and health care providers). Be sure that the implementation plan includes feedback from relevant individuals (the patient, family and friends, health care providers).

5. MAKE YOUR CHOICE

Live with your choice and learn from it! Seek feedback on the process from all those involved. Take the opportunity to reflect on how you will deal with other challenging situations in the future. Consider organizing follow-up debriefings, continuing education sessions, and, if needed, make changes to related policies and procedures.