Public Health Ethics Textbook Analysis

Monica Gosal

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By Monica Gosal

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Supervisory Committee:

Dr. Marjorie MacDonald, RN, BN, MSc, PhD

(School of Nursing)

Dr. Rosalie Starzomski, RN, BN, MN, PhD

(School of Nursing)

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Area of Interest

Introduction and Background

Nursing education has evolved since the profession was first recognized and established within academic settings. In fact, the first school of nursing within a university setting was located at the University of Minnesota in 1909 (Jacobs, Dimattio, Bishop, & Fields, 1998), and within the following 11 years, 180 schools of nursing reported being associated with colleges (Jacobs et al., 1998). Nurses use textbooks during and after college and university programs, continuing education, and professional development to develop, expand, and reinforce their learning and knowledge as practicing professionals. With the engagement and use of varied teaching-learning strategies and the innovation of new and improved technologies and tools, the education setting is changing. The foundations of nursing education, principles of practice, and nursing theory and knowledge are expanding. More knowledge is being built continually upon these foundations.

Public health is a specific area of nursing speciality that requires a particular knowledge base. Public health consists of dynamic collaborative relationships among health care professionals, including and not limited to dietitians and nutritionists, dental hygienists, audiologists, environmental health officers, physicians, nurse practitioners, and registered nurses. Public health nurses are developing, expanding, and reinforcing their knowledge continuously, often referring to textbooks for information and using these resources as tools for ethical decision making. Ethical decision making by public health nurses affects not only the individual being served but also the families, communities, populations, and generations impacted by the course of actions. Community health nursing textbooks are important resources for learning about

ethics and for providing guidance for ethical decision making and in this study my particular interest is with these textbooks.

In this project, public health nursing textbooks were analyzed with the goal of assessing ethics content. An analysis was conducted to determine which ethical concepts, principles, and theories are addressed in community health nursing textbooks. Before I present and discuss my findings, I will discuss public health ethics, examine common ethical theories and perspectives, and present a few ethical decision-making frameworks. Specifically related to this project, an overview of public health ethics and ethical theories provides a foundation for the textbook analysis and further provides a knowledge base to determine the scope and relevance of the texts analyzed. By providing this background information, the findings will be placed into a more meaningful context to guide everyday public health practice. The ethical knowledge which public health nurses require to practice and make decisions upon are unlike that of acute care settings. A key difference is that acute care practice centers around individuals with a focus on treatment, while public health practice centers around communities and populations with a focus on health promotion and prevention. This analysis of textbooks within current public health and community health textbooks is important as it provides an assessment of the ethical content of these texts for public health nurses.

Public Health and Public Health Ethics: What Are They?

There are many definitions of public health and public health ethics. The focus in public health is on groups of individuals (communities and/or populations) rather than strictly on individuals (Kenny, Sherwin, & Baylis, 2010; Paradis, 2008; Schabas, 2002; Walley, 2010). Upshur (2002) stated that “the focus of public health is directed to populations, communities and the broader social and environmental influences of health … there is a greater focus on

prevention than on treatment or cure" (p. 101), as well as health promotion within public health. Simply stated, public health is about improving the health of the population by understanding public health problems and intervening (Walley, 2010). Public health professionals work in collaboration to provide care and have a positive impact not only on individuals but also on families, communities, and populations.

Kenny, Melnychuk, and Asada (2006) stated that public health ethics is "contrasted to medicine in focussing on: the health of populations rather than individuals; disease prevention and health promotion rather than treatment and cure; long-term rather than immediate effects; political action and inter-sectoral collaboration" (p. 403). The National Advisory Committee on SARS and Public Health indicated that public health has six important functions: health protection; health surveillance; disease and injury prevention; population health assessment; health promotion; and disaster response (Health Canada, 2003; Kenny et al., 2006). Public health entails that we understand the environment, communities, and the world we live in, and implement ways of improving them through actions, such as health promotion and preventive interventions to promote social justice and decrease health inequities; and vise versa improve health inequities and social justice to promote health promotion.

The responsibility of public health professionals is to society as a whole rather than to individuals; the societal responsibility is represented by governmental policies and legislation (Schabas, 2002); not all individuals may engage in the belief of societal responsibility, and may rather relate to individual responsibility – a self responsibility. Public health programs and interventions are developed and implemented for the benefit of the population; "the 'fiduciary role' is with society as a whole" (Schabas, 2002, p. 98). However, the practice of public health professionals must be balanced between providing care to individuals and maintaining and

promoting the health of the greater population. Public health professionals encounter many ethical challenges and concerns as a result of trying to balance care; for example immunization policies and funding for high risk populations versus less high risk populations based on ethnicity alone. Hepatitis A, being a specific example; the aboriginal population is at greater risk living on the reserve, however being aboriginal is the only criteria for being funded within British Columbia for immunization coverage, rather than a focus on the actual risk factors causing the risk.

Public health ethics guide public health professionals towards a course of action that will promote the overall health of individuals, groups, communities, and populations. Schabas (2002) states:

> [G]ood intentions are not enough. If public health wishes to suggest that people stop doing things they enjoy or start doing things they may not otherwise choose to, we should be sure of our ground. There are two reasons for this. The first is the potential for bad advice to do actual harm. The second is the inherent harm of intruding into people's lives. (p. 99)

Thorne, Best, Balon, Kelner, and Rickhi (2002) stated that "ethics, or the study of how we might determine morally correct action under various circumstances, requires some consensus or agreement as to how we will be able to know the greater individual or social good" (p. 908). Public health professionals make decisions that at times can result in sacrificing the good of an individual for the good of the community—for the greater good of society. Public health professionals face many challenges and an ethical foundation in public health and understanding can help guide practice, especially during challenging situations. Public health nurses make up approximately one-third of the total public health workforce; there were approximately 12,000 public health nurses in Canada in 2004 (Public Health Agency of Canada, 2004). The large

number of nurses within public health requires a public health ethics foundation to practice upon, and on which they can base their decisions. Knowledge of public health and all of the concepts, roles, standards, and principles need to be part of health curricula and taught to all public health professionals.

In my project, I analyzed the ethical content of currently available community health and public health textbooks for the purpose of determining current ethical knowledge among public health practitioners. I will discuss relevant philosophies, theories, and concepts within ethics and public health ethics. Then I will examine common ethical decision-making models. Finally, I will present the results of the analysis of the textbooks, a discussion, and a summary of the findings.

Significance of this Project

Purpose/Aim of my Proposed Project

The purpose of this project was to analyze the current Canadian nursing textbook content available on public health ethics and determine which nursing textbooks provide current ethical content specifically relevant to public health in general and public health nursing specifically. The analysis of the ethics content in public health nursing textbooks was intended to help determine whether the public health ethics content is increasing/evolving/changing, and whether the ethical content aligns with the emerging theory and practice in public health ethics, namely relational ethics.

Zahner (2000) published *Ethics Content in Community Health Nursing Textbooks*, which was the starting place for my project. Zahner presented an analyses of the public health nursing and community health nursing texts in the United States that contained ethics content. However, this study is now 12 years old. An additional analysis of textbooks, specifically Canadian texts,

provides an opportunity to determine the status of public health ethics content in current Canadian public health nursing textbooks.

Statement of Problem

As indicated by Zahner (2000), public health ethics content in community health nursing textbooks is limited. Zahner found that the ethics content in community health nursing texts had changed and evolved over a considerable period of time. She noted, however, that the overall ethical content in the texts was "disappointing". Without a solid understanding of and/or foundation for public health nurses to base their ethical decision making on, nurses may be limited in their ability to substantiate their choices, actions, and practice. The specific question I wanted to answer was, "Which ethical theories are presented in public health nursing and/or community health nursing textbooks and which textbooks provide the most well-rounded source of information in Canadian public health ethics for nurses?" A Canadian perspective on public health ethical content in community health nursing textbooks can provide a solid foundation and overview of the current public health ethics literature in nursing, as well as a basis for change, development, progression, and/or reflection. My assumption prior to commencing this analysis was that since Zahner's (2000) study, there would now be a more concise and relevant representation of ethical theories and decision-making frameworks for public health nurses to base or guide their practice.

Public Health Ethics: Of, in, for

Public health professionals' responsibility to the population creates a dilemma for professionals who are regulated by bodies with an individual-client focus rather than a population-client focus. Professionals are taught advocacy for individual clients, rather than advocacy for the greater population. Gostin (2001) notes three distinctions of public health

ethics: ethics *of* public health, ethics *in* public health, and ethics *for* public health. Public health professionals, including public health nurses, work across the three distinctions.

The ethics *of* public health (EOP) encompass professional ethics and refers to the trust that society bestows on professionals to act for the common good (Gostin, 2001). The public and licensing parties are expected to hold professionals accountable for their ethical standards of practice. However, regulatory professional bodies set codes of ethics and standards directed primarily towards the care of individuals, rather than populations.

Ethics *in* public health (EIP) refers to applied ethics and the moral standing of the population's health. EIP balances the interests of the collective good and those of individuals (Gostin, 2001). EIP includes the principle of social justice, which is the equitable allocation of benefits and burdens (Gostin, 2001). Ethics *for* public health (EFP) refers to advocacy ethics, and the overriding value in establishing healthy communities (Gostin, 2001). EFP is a guide to serve the interests of populations, particularly the powerless and oppressed (Gostin, 2001). Ethics *in* public health and ethics *for* public health help guide the public health professional's practice and decision making; therefore, it is important for public health professionals to understand ethical concepts and theories to apply them *in* and *for* public health. Below, I discuss relevant ethical philosophies, theories, and concepts taken into consideration when addressing ethics *in* and *for* public health ethics and public health practice.

Philosophies, Theories, and Concepts

Deontology, utilitarianism, virtue ethics, communitarianism, and principlism are common theoretical perspectives within healthcare ethics. Guiding principles such as: utility, efficiency, liberty, transparency, participation, effectiveness, fairness, reciprocity, and solidarity are some of the many principles found discussed within healthcare ethics. These common theoretical

perspectives were included in public health and community health textbooks as relevant theories applicable to public health nursing practice. Accordingly, public health ethics needs to be a reflection of public health's goals – community and population centered.

Deontology

Deontology is a duty-based theory that focuses on practitioners performing the "right action" regardless of the consequences (Berglund, 2007). Within a deontological ethical approach, the action is completed due to the perceived moral obligation to complete it. In public health, the ultimate goal is to improve population health and reduce health inequities; thus, consequences are important and deontology may not completely align with public health's goals. Therefore, deontological-based ethical decision making can potentially harm the population as a whole; programs and interventions may be initiated without foreseeing the results. For example, a public health nurse has the duty to provide evidence-based standards and information when mothers discuss infant sleep and bed sharing (in mother–babe group settings). The recommendations based on evidence and the information that is to be provided to mothers with new babes is that bed sharing is not recommended; rather, co-sleeping (that is a babe in a crib with a flat hard mattress in the same room) is the recommendation. Following the deontological approach, a nurse using standards and recommendations could give this information and state that this is what needs to be done—and expect it to be completed. However, the reality is that parents bed-share. Thus, to prevent sudden infant death syndrome, it could be detrimental to not provide information on safe ways to bed-share if it were to occur. The public health nurse has a duty to give parents recommendations that are evidence-based and approved by reliable sources (Health Canada). However, public health nurses also have a duty to the safety of the child, as well as a duty to their profession and employers to provide information that is "approved." The

nurses duty to the safety of the child and duty to the parents requires ensuring parents have all the information to bedshare safely, however this duty at times challenges the duty to the employer for information practitioners are “eligible” to share based on policy.

Principlism

Principlism as an ethical decision making approach is guided by four basic principles: autonomy, non-maleficence, beneficence, and justice. It is an ethical stance criticized within public health ethics, yet is commonly discussed within public health and community health textbooks. Autonomy is an individualistic principle and as such considers the benefits for individuals; however, when applied to public health, there is conflict between an individual’s decision to self-rule and public health practice’s population-based moral mandate. Autonomy is important for individuals to promote empowerment, self-rule, and respecting human dignity (Berglund, 2007). The beneficence principle is meant to maximize benefits to individuals and the population (Berglund, 2007). In health care ethics, specifically bioethics (which falls alongside public health ethics), benefits to individuals are prioritized over benefits to populations, although the principle can be applied to both individuals and to the larger population. The non-maleficence principle is meant to minimize harm to others (Berglund, 2007). The challenge for public health professionals is that sometimes minimizing harm to the population puts individuals at risk of harm. The justice principle is about the fair distribution of the benefits and harms, and of the community resources and burdens (Berglund, 2007). Distributive justice (justice principle) is based on the notion that people who are equal should qualify for equal treatment; however, there is no indication to how this equality should be determined. With distributive justice, equality can be determined by criteria such as age without a look at other factors; “equality” becomes the changing factor. Distributive justice, when

applied to the goals of public health, does not address a community approach to justice; rather, it is an individualistic approach.

Principlism, as an ethical concept applied within public health is difficult to understand; it encompasses a well established set of principles applicable to acute care practice settings and within the individual context. Principlism often uncovers the benefits and harms to individuals as well as discovers resource needs and accessibility. Principlism benefits individuals rather than the greater population and thus can be applied only partially to the population at large. Society needs community-based principles with foundations rooted in community-centered care. Further a principlism approach does not address the complex ethical decision making required by public health professionals.

Consequentialism and Utilitarianism

In a consequentialist perspective the focus is on the consequences and attempting to avoid harm or bad health outcomes (Berglund, 2007). Consequentialism is "holding that actions are right or wrong according to the balance of their good and bad consequences" and determining "the rightness or wrongness of actions" (Beauchamp & Childress, 2009, pp. 336–337). Further, consequentialist theory does not distinguish which consequences are good or acceptable and which are harmful or unacceptable (Holland, 2007).

A utilitarian approach, a type of consequential theory, attempts to maximize the greatest good by maximizing the distribution of that good (Berglund, 2007); in other words, the greatest good for the greatest number of people. Theorists fail, however, to quantify "good," and fail to indicate how much "good" needs to be achieved prior to implementation of an intervention. If an intervention maximizes good through distribution among a group while overlooking another (slightly smaller) group that may be disadvantaged by the benefit to the one group, the

intervention is still considered good from a utilitarian perspective. Beauchamp and Childress (2009) described utilitarianism as the concentration being

> [O]n the value of well-being, which may be analyzed in terms of pleasure, happiness, welfare, preference satisfaction, or the like . . . . we ought always to produce the maximal balance of positive value or disvalue (or the least possible disvalue, if only undesirable results can be achieved). It is often formulated as a requirement to do the greatest good for the greatest number. (p. 337)

Holland (2007) additionally pointed out that there are no criteria that indicate which course of action to take in implementing programs; if there are two competing policies that provide maximum benefit to populations, there is no indication which policy is better than the other.

Human rights

A human rights perspective borders between individual ethical rights and the rights of a community/society/population as a whole. Although human rights arises from a legal and not an ethical framework, human rights has an important foundation to healthcare practitioners practice to ensure appropriate care is being provided. Where possible, it ensures a balance between the rights of the individual and the rights of the population. The definition of human rights from the Department of Justice Canada (2008) is as follows:

> The principle that all individuals should have an opportunity equal with other individuals to make for themselves the lives that they are able and wish to have and to have their needs accommodated, consistent with their duties and obligations as members of society, without being hindered in or prevented from doing so by discriminatory practices based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status,

> family status, disability or conviction for an offence for which a pardon has been granted. (p.1)

The human rights perspective ensures that individuals be provided with a chance at an equal opportunity that another individual within the same society would be privileged to. The balance of rights of the individual and the rights of the population stems from the rights individuals have *within* the population. The community, which is comprised of individuals, all are entitled to the human rights act. If a right or opportunity is available for one individual within a population, that same right on the grounds of human rights and equal opportunity is available to all the individuals within the population (Easley & Allen, 2007).

The human rights perspective cannot be ignored when it comes to public health ethics; human rights play a role in decision making when it comes to public health practice and/or policies. In public health, the rights of individuals often are not prioritized as being greater than the benefit to the community or population as a whole; however, there is an attempt not to violate the rights of individuals, when possible. Public health ethics ensures that the population has programs and/or interventions in place to benefit the community/population as a whole; human rights is an essential theory which ensures that public health does not dominate over individuality. However, public health acknowledges that it cannot always focus on individuals or specific groups; the ultimate goal is the greater good. The purpose of human rights is to ensure that the rights of individuals are not trumped for the rights of the collective.

Communitarianism

Communitarianism is an important and relevant theoretical perspective in regards to public health. Supporters of communitarianism, while privileging the community over individuals, do acknowledge the strong integral connection between the individual's and the

community's needs, and attempt to address the rights of both the individual and community. Feminist ethics and relational ethics are both classified as communitarian theories.

> Feminist ethics draws attention to the distinguishing characteristics of relationships and the power within those relationships at individual, group, community, and societal levels. Based on the core ideal of achieving social justice, feminist ethics extends the principle of justice and the notion of distributive justice to consider social structures and contexts. (Racher, 2007, p. 70)

The focus of relational ethics is on the community and the individual members within the community, recognizing that the good of the community is the goal (Berglund, 2007). In the following section, I will briefly discuss feminist ethics and relational ethics, both of which acknowledge the individual within the community while guiding public health nurses in practice with a community and population focused agenda.

Feminist ethics. Feminist ethics addresses the oppression of people and the moral and political injustice to both individuals and communities. The focus of feminist ethics is relational rather than individually focused, and entails relational ethics. Feminist ethics involves the ethical principles of equity. In considering equity, the intent is to strive for equitable or just treatment of all individuals. Rector (2010) stated that "the principle of equity implies that it is unjust (or inequitable) to treat people the same if they are, in significant respects, unalike" (p. 82). Individuals have different needs within health care, and that access to health care should be attainable by all and according to individuals/groups needs, rather than an approach of "one size fits all."

Relational ethics. Similar to feminist ethics, relational ethics (Berglund, 2007) focuses on the community, and the individual members within the community, recognizing that the good

of the community is the goal (Berglund, 2007). Petrini (2010) stated that moral thinking originates from within a community's traditions and that communities are composed of "individuals: they are groups of individuals who share values, customs, institutions, and interests" (p. 192). Petrini (2010) indicated that the goal of communitarian ethics is a shared common good: "health of the public is one of those shared values: reducing disease, saving lives, and promoting good health are shared values" (p. 193). The concern with communitarianism, as suggested by Petrini (2010), is determining what constitutes the common good and what community traditions will be distinguished as those that public health uses to develop programs.

Baylis, Kenny, and Sherwin (2008) discussed relational ethics as an ethical approach relevant for public health ethics. Relational ethics is "rooted in a relational understanding of persons … relational ethics insists that persons be treated as the socially interdependent beings that they are" (p. 10). Relational ethics includes notions such as relational personhood, relational autonomy, relational social justice, and relational solidarity. Baylis et al.'s relational ethics can be recognized as ethics *in* public health; relational ethics encompasses principles that help guide public health professionals' practice. Relational ethics is founded on the understanding that people are interconnected with others as social beings. The descriptions of relational personhood, autonomy, justice, and solidarity below draw on Baylis et al.'s perspectives in regard to relational ethics.

Relational personhood. Relational personhood implies that individuals determine who they are through social interactions and relationships (Kenny et al, 2010); in other words, individuals determine who, how, and what they are as a result of how they perceive themselves within a larger group or community. Furthermore, within the concept of relational personhood, social inequalities and inequities become transparent. Relational personhood provides a lens for

public health professionals to take into account the communities' demographics, status, and determinants of health prior to implementing new programs and policies.

Relational autonomy. Relational autonomy is sustained through social being and social change, and the understanding that people exist and engage in change resulting from their social relationships (Kenny et al, 2010); that is, those built within the community and society in which they live. Relational autonomists suggest that individuals within the social setting may be limited in decision making for individual benefit as a result of being interdependent on society; in other words, individuals may make alternative choices that result in a benefit for all versus a benefit for self (Kenny et al, 2010). Further, these theorists have suggested that the benefit achieved through relational autonomy, if the primary focus, will result in a different reward, one beyond self. Specifically, autonomy within the relational perspective is sought after in social rather than individual contexts. Public health nurses will have to address the community's choices and implement recommendations and policies which may not be the agenda of a specific community, but may be in public health's agenda for the greater good.

Relational social justice. Relational social justice is about fair access to rights, opportunities, and health care for all individuals, particularly for those groups of people and populations who experience systematic disadvantage (Kenny et al, 2010). The goal of relational social justice is to minimize or eliminate the effects of systematic disadvantages for individuals and populations. Within public health, this is a beneficial concept. Practicing relational social justice leads to fairness and justice when promoting public health activities and attempts to provide equal opportunity by reducing the barriers—which is essential to the oppressed and disadvantaged. This concept can motivate public health professionals to implement policies and programs that can help reduce the inequities that exist.

Relational solidarity. The aim of practicing relational solidarity is to promote inclusion of social groups and embrace differences; individuals/groups recognize and address factors resulting in oppression and disadvantages. Relational solidarity is a useful concept within public health, mainly as a notion that the population has a shared interest for public safety, survival, and security (Kenny et al, 2010). In relational solidarity, individuals see themselves in a partnership with others; the effects of actions on others ultimately will have an effect on themselves.

To develop and implement public health programs, professionals need to deliberately engage with relational ethics to ensure that the concerns and needs of disadvantaged groups are considered. Individuals, groups, communities, and populations perceive themselves as existing within and alongside each other—an impact on one will have an impact on others. In other words, individuals are seen as forming a community; although being composed of individuals, the community has characteristics that transcend the characteristics of its individual members. One does not exist without the other but rather they exist with an emphasis on an "us all" (Kenny et al, 2010). Further, public health issues, concerns, and interests are deemed as shared rather than experienced individually.

A tension exists between a human-rights perspective (individual rights) and a public health perspective (community or collective rights). Individuals exist within the context of a community and society; a community is created with the involvement of individuals, which is the focus of relational ethics. The difference between human rights and relational ethics, both of which can balance the rights of individuals and populations, is that human rights are about individuals at its core; relational ethics are about the population or community at its core and considers individual rights to the extent possible, while impacting the health of populations and individuals. Human rights protects the minority in the presence of the majority; for example, in a

community setting, a human rights perspective ensures that an individual who can be singled out due to culture, religion, beliefs, finance, etcetera, is not overpowered and ignored by a community-based ethical perspective. Public health ethics tension exists at the core of the theory used to take action: individual or population, or one community over another—whose rights are deemed greater? If individuals exist within communities and communities exist with individuals, whose right is of focus: the individual *in* the community or the community *of* individuals? Here lies the greatest tension within public health ethics. Relational ethics (discussed below) attempts to address this tension as it has less tension and more balance between the two (individuals and communities) than do other theories, such as consequentialism, utilitarianism, principlism, and virtue ethics, all of which privilege one over the other with a less balanced perspective.

Additional Ethics Perspectives

Two additional perspectives commonly presented alongside the above noted perspectives are virtue ethics and ethics of caring.

Virtue ethics. Beauchamp and Childress (2009) described virtues as "a trait of character that is socially valuable and a moral virtue is a trait of character that is morally valuable" (p. 31). In applying virtue ethics, the intent is not only for moral actions to be completed but also for individuals to act with moral character. The issue with virtue ethics is the unknown answer of what makes an act moral and how is a person judged to be of moral character. Rather, virtue ethics focuses on the moral behaviour behind the cause of the action, not the action itself.

Ethic of caring. Ethic of caring is described by Kurtz and Burr (2009) as an ethic with a focus on relationships and responsibilities, rather than on rights, obligations, and outcomes; furthermore they state that the "primary focus is on the well-being of the whole person" (p. 261). The ethic of caring is another philosophy that is individualistic rather than community-

centered. The well-being of the whole person focuses on the individual's well-being physically, psychologically, and spiritually; however, this ethical focus fails to see the community attached to the individual.

Ethical Decision-making Frameworks

> Ethical decision making is that component of ethics that focuses on the process of how ethical decisions are made. It involves making decisions in an orderly process that considers ethical principles, client values and abilities, and professional obligations, and it occurs when healthcare professionals must make decisions about ethical issues and ethical dilemmas. (Stanhope et al., 2011, p. 166)

Ethical decision-making frameworks help public health nurses in courses of action, whether that is direct interaction with the community or through such actions as developing and implementing public policy, as well as to implement and evaluate decisions while applying ethical philosophies, theories, and principles within their interactions. Ultimately, decision making is determined by the theory while frameworks are the building blocks of the decision making process.

Advocacy

Advocacy is a principle that is useful for both an individual and a community. Advocacy is not an ethical principle though it "is a process, not an outcome, one that includes identifying an issue, collecting information, identifying who can be influenced/who can make the decision sought, building support, and taking action" (Bourne, 2010, p. 356). Individual health advocacy focuses on the need, awareness, and support for an individual whereas community health advocacy (Bourne, 2010) refers to the same efforts of need, awareness, and support, but the recipient of the need is the community as a whole. Advocacy is a process that is beneficial to the

individual and the community; it does not provide a greater benefit to either party, but is equally valuable with either an individual or a community perspective in mind. Two types of advocacy framework models in public health are the practical and conceptual advocacy frameworks, which are briefly described below.

Practical. Silva, Fletcher, and Sorrell (2010) described Bateman's practical framework for advocacy, which includes six ethical principles:

1. Act in the client's (group's, community's) best interests.
2. Act in accordance with the client's (group's, community's) wishes and instructions.
3. Keep the client (group, community) properly informed.
4. Carry out instructions with diligence and competence.
5. Act impartially, and offer frank, independent advice.
6. Maintain client confidentiality. (p. 63)

In applying this practical advocacy framework, the PHN works with, not for, the group or community. Without the participation of the group or community, advocating for the needs and interests of the community would not be feasible.

Conceptual. Christoffel (2000) presented a framework for public health advocacy that progresses through three stages: information, strategy, and action. Christoffel (2000) stated that, in practice, the three stages occur simultaneously. The information stage is about collecting data that will determine such factors as the effectiveness, barriers, risks, and need of the public health program. The strategy stage is about the process of providing the information to professionals and the general population. The action stage is about implementing specific strategies, such as passing laws. Christoffel (2000) listed activities of public health advocacy as follows: problem

identification, research and data gathering, professional and clinical education, development and promotion of regulations and legislation, endorsement of regulations and legislation via elections and government actions, enforcement of effective policies, and policy process and outcome evaluations (p. 723).

Both the practical and conceptual framework of advocacy can be applied to public health practice in helping public health nurses guide ethical decision making; however, the advocacy model does not set the standard which group or community to advocate for when challenged by two opposing interests or needs. At first glance, the advocacy framework, whether practical or conceptual, includes steps or phases to follow; however, it does not provide enough context for professionals to make ethical choices in situations when the interests are equal.

Moral considerations and justificatory conditions

Childress et al. (2002) identified five "justificatory conditions" to guide workers as to when public health interventions may be ethically justified in prevailing over individual rights and values: effectiveness, necessity, proportionality, least infringement, and public justification. Childress et al. (2002) also indicated that that public health professionals need to address a set of nine general moral considerations to justify public health actions. They suggested that if the nine moral considerations were not addressed and/or conflict arose amongst the moral considerations during public health action implementation, the justificatory conditions needed to be considered and applied to resolve conflict. Moral rules are rule-based reasoning, and the nine moral considerations are explanations or justifications of actions as right and wrong. Moral considerations can become complicated as a result of different interpretations of what values, morals, or beliefs are "right." The justificatory conditions attempt to rationalize the decision and/or course of action being taken. In other words, the nine moral considerations are the

reasoning and the justificatory conditions are the rationality behind the implementation and course of action undertaken.

Nine moral considerations. Childress et al. (2002) identified the following moral considerations that need to be addressed prior to implementing public health actions: Producing benefits; avoiding, preventing, and removing harms; producing the maximal balance of benefits over harms and other costs (often called utility); distributing benefits and burdens fairly (distributive justice) and ensuring public participation, including that of affected parties (procedural justice); respecting autonomous choices and actions, including liberty of action; protecting privacy and confidentiality; keeping promises and commitments; disclosing information as well as speaking honestly and truthfully (often grouped under transparency); and building and maintaining trust (pp. 171–172).

During the H1N1 pandemic and the shortage of vaccines in 2009, public health professionals were faced with the difficult decision of determining when and if to proceed with individual isolation (confinement/quarantine to the home), control of spread, and eligibility for receiving a vaccination. Practitioners were required to implement public health actions taking into account the general moral considerations. Childress et al.'s (2002) justificatory conditions of effectiveness, proportionality, necessity, least infringement, and public justification are conditions to guide public health professionals' practice when facing conflict among the nine moral considerations in situations such as those encountered during the H1N1 pandemic.

Effectiveness condition. The effectiveness condition is to be used regarding such ethical dilemmas as determining which individuals would be quarantined. The effectiveness condition further suggests that quarantine can be considered if there is a reasonable probability that it would be successful in addressing the protection of the public's health.

Necessity condition. The necessity condition includes interventions or actions that are required in order for the health of the public to be achieved. In other words, the public health action is essential to achieve public health's goal. The necessity condition is used to consider whether the action is necessary based on the knowledge available. With regards to quarantining during the H1N1 pandemic, the need for confinement would be considered even if there is no evidence on the effectiveness of controlling and/or resolving the pandemic. Quarantining and confinement can be initiated to err on the side of caution for public safety, due to limited and "imperfect" knowledge availability.

Least infringement condition. The least-infringement condition is based on the notion that the action causing the least amount of violation to the rights of individuals and/or communities will be implemented—for example, by requesting individuals to voluntarily quarantine themselves versus mandatory quarantine. Even if the effectiveness and necessity conditions were to be considered for the protection of the population, public health professionals still should attempt to minimize violation of individual rights.

Proportionality condition. The proportionality condition includes the notion that quarantining individuals may infringe on the individuals' general moral considerations; however, the benefit to the public's health outweighs the individuals' restrictions. An important factor considered is that the action proposed must be in proportion to the risk imposed. This condition allows individual to take into consideration whether the public health action would be effective, necessary, and least restrictive; if these conditions are met, the public health action can be considered proportionate.

Public justification condition. The public justification condition is meant to stress the importance of public health professionals discussing public health actions and interventions

openly and transparently. The public requires an explanation regarding the decision making process such as how decisions were made regarding who was eligible to receive the H1N1 vaccination. When public health actions are implemented, the communities are affected by the actions of public health directly or indirectly and therefore require an explanation that includes accountability for the reasons, explanations, and justifications of the actions proposed. Public health actions can infringe on one or more moral considerations and the public needs to be made aware of the infringements (Childress et al., 2002). By making individuals aware and informing them of the reasons behind the decision making and actions, there may be less resistance to the actions proposed. Public health professionals will have to develop relationships and build trust with community members through transparency of public health decision making.

The five justificatory conditions are not set in stone in the form of rules or laws, but they provide guidance to public health professionals when faced with challenges and dilemmas that may need to be addressed. These conditions also help practitioners make appropriate decisions among competing options and choices.

Principles of Public Health Ethics

Benatar and Upshur's (2008) and Childress et al.'s (2002) ethical decision-making frameworks follow similar criteria and attempt to balance public health interventions and decision making while preserving the rights of the individual as well as the rights of the community. Attempts to balance within these perspectives can cause tension and conflict for public health professionals when faced with ethical challenges or impasses. Both the seven principles and the justificatory conditions address the principles of effectiveness, proportionality, necessity, least restrictive/least infringement, and transparency/public justification (discussed above); the differences are noted with Benatar and Upshur's principles of harm and reciprocity.

Benatar and Upshur have further built on a pre-existing ethical framework, namely the justificatory conditions, and addressed concerns of harm to individuals as well as proposed assistance to individuals in implementing the public health action being proposed. The seven principles of public health ethics can be recognized as ethics *in* public health, which focuses on the moral standings of the population's health and helps guide professional practice. The harm and reciprocity principles introduced by Benatar and Upshur (2008) add to the conditions/principles established by Childress et al. (2002). The harm principle suggests public health actions may restrict an individual's rights/desires only if it prevents harm to others; however, the harm principle does not delineate what degree of restriction to an individual's rights/desires is acceptable. The reciprocity principle states that appropriate assistance should be available to individuals if they are required to take action that may have negative consequences for themselves; this principle does not indicate a means to measure what entails "appropriate" assistance.

Theories and Frameworks; Bringing Them Together

Different philosophies and principles highlight different concerns that provide areas for reflection and consideration during decision making. Frameworks provide a lens or perspective from which to apply the reflection and attempt to resolve the ethical concern and/or conflict. Currently, there is no agreed-upon public health ethical theory or approach to ethical decision making in public health (Kenny et al., 2010).

> Public health ethics requires an approach that is itself "public" rather than individualistic, i.e., one that understands the social nature and goals of public health work. It must make clear the complex ways in which individuals are inseparable from communities and

> populations and build on the need to attend to the interest of communities and populations as well as individuals. (Kenny et al., 2010, pp. 9–10)

Because public health professionals face many challenges, a public health ethical foundation and understanding can help guide practice, especially during challenging situations. Public health professionals need an ethical knowledge base to ground their actions and to be able to reason and support their decision making in conjunction with developing their professional knowledge base.

Professionals applying relational ethics approach situations and challenges from the perspective of the collective and see individuals within the context of community, rather than individuals and communities as separate. Public health practice is itself relational and interdependent among the groups, populations, and communities served. As a result, relational ethics may be the solution to addressing ethical concerns in public health nursing practice since it addresses the tension that exists when making ethical decisions involving individuals and the collective. The other concepts, philosophies, and theories (specifically deontology, principlism, consequentialism, utilitarianism, feminist ethics, and virtue ethic) may not be adequate to address the ethical decision making concerns that public health nurses face because the majority of the concepts, philosophies, and theories do not adequately address the concerns of individual and collective rights, and social inequity.

The challenge for public health professionals concerning ethical decision making is to determine which ethical decision making concepts, principles, theories, and decision-making frameworks to utilize in practice, and when to utilize one of the many frameworks available. Public health nurses face this dilemma in practice and rely on the knowledge they gain during their academic and continued studies to best meet the needs of both the community and the

profession. I believe that relational ethics addresses the challenge of balancing the care of individuals within the communities and the communities within a larger context.

Methodology

Sampling

Textbooks included in the analysis for this project were Canadian community health texts and texts from other countries that are frequently or most likely to be used in Canada All of these texts have been published since 2000. Based on an informal survey of community health texts used in Canadian schools of nursing conducted by Marjorie MacDonald in 2001 (personal communication), the most frequently used American texts were those written by Stanhope and Lancaster, Allender and Spradley, Clark, and Anderson and McFarlane. In undertaking this project, Ferreira's (2012) identification of community health texts used in Canadian schools of nursing was considered. She suggested that the most frequently used Canadian texts included those written by Stanhope and Lancaster (2008 and 2011), Stamler and Yiu (2008 and 2012), and Vollman, Anderson, and McFarlane (2008 and 2012). Thus, texts by these authors were included in the analysis. Only textbooks in English and those specifically written for public health nursing or community health nursing were included. These texts generally contained the words public health nursing, community health nursing, community, community health, or public health in the title. For the purposes of this project, I analyzed the most recent edition (2011 or 2012) of texts with second, third, and later editions. In addition, I compared the most recent edition of the text available in 2012 to the multiple editions of that text published since 2000 to analyze the changes and/or progression of the ethics content in the text. Appendix A presents a reference list of the texts used in the analysis.

Framework

The framework for this review of public health ethics content within nursing textbooks is based on the work of Zahner (2000), which was used as a foundation to develop a framework and template to guide the analysis of textbooks containing public health ethics content (see appendix B). The framework is a chart used to extract and sort the content on ethical theories and frameworks described in the various texts. For each textbook analysed, I identified the theoretical bases, ethical frameworks, and ethics content related to or having implications for public health. The framework is a chart that was used to extract and sort the content present in the texts I analyzed; notes in the form of texts were placed in the rows/columns analyzing the content discussed within the textbooks specifically related to the ethical theories and frameworks. The data analyzed which textbooks discussed the theoretical bases, which include ethical frameworks, and which textbooks discussed ethics related to and the implications to public health. Content within the textbooks were located through the table of contents and the index; ethics chapters were analyzed, as well as through pages indicated in the index specific to common terminology (specific word/term searches: deontology, utilitarianism, communitarianism, relational ethics...principles, ethics, theory...decision-making, frameworks...advocacy, moral considerations, justificatory conditions, Kass's six-step framework, and so forth).

Appendix Overview

I have taken the opportunity here to discuss the appendices at the end of this paper, to provide the reader with clarification. The five appendices are Appendix A, Textbook Reference List; Appendix B, Framework; Appendix C, Theories and Principles chart; Appendix D,

Decision-making frameworks chart; and Appendix E, Ethical decision-making framework definitions.

Appendix A

The textbook reference list includes the textbooks analyzed for the project. The textbooks in this section are listed alphabetically by book title and then sorted chronologically by text edition. The purpose of organizing the texts in this manner was for ease of readability. By grouping together the title of texts, rather than author name, the reference list did not disperse the various editions of the same texts throughout the list if or when the author(s) of the chapter being analyzed changed.

Appendix B

The framework containing the data collected from the textbook analysis is presented in a table format, allowing for comparisons to be made over similar categories, as well as comparisons over editions. The data collected are presented under the following categories: Textbook author(s)/editor(s), chapter author(s), year, textbook title, edition, number of pages, overall percentage of coverage, theory/theories addressed, frameworks addressed, changes/progression over editions, discussion of ethics theory/concepts, implications for and ethical challenges within public health, and additional comments/notes. Overall percentage of coverage is the percentage of pages with ethics content within the textbook from page one to the index.

Appendix C and D

Appendix C presents a chart of principles, theories, and philosophies noted in the textbooks during the analysis. The chart provides a quick glance at the range and types of ethical content the textbook provides to its readers. This representation also shows the similarities and

differences over textbook editions, as well as textbook titles. These same findings can be gathered through Appendix B; however, this list offers easy readability and a quick reference or resource.

Appendix D is similar to Appendix C, except the content represented is decision-making frameworks rather than specific principles, theories, and philosophies. It also includes a representation of the similarities and differences over textbook editions, as well as textbook titles.

Appendix E

Appendix E contains a list of ethical decision-making frameworks noted during the text analysis. Provided alongside is a brief description of the frameworks to utilize as a reference.

Results

In this section, I present the results of the completed analysis on the selected community health and public health textbooks. Included is general information on the texts analyzed and a brief comparison of the findings. The texts will then be discussed by country, comparing the editions; also, the Canadian texts will be compared with the United States text of the same title or by the same authors.

Overview

A total of 27 texts were analyzed for this project (see Appendix A). Of them, 24 were revised editions of texts, 10 were Canadian, one was from the United Kingdom, two were from Australia, and the remaining were American. All but four of the 27 texts included chapters on ethics. Texts with no ethical content comprised 16.7% of texts. One text contained minimal ethics content, that is, a subsection within a chapter; three texts contained no ethics chapter and no ethics content. Of the 23 texts with ethics content, that content ranged from 1.2 to 4.0% of

the total text in the book. These calculations are approximate, based on the total number of pages from the first page of content to the beginning of the index. The texts with 1.2% coverage of overall content were McMurray (2007) and Clark (1999); the text with 4% coverage was Stamler and Yiu (2005). The number of pages of text content on ethics ranged from five to 21. McMurray (2007) had the lowest number of pages (N = 5). Vollman, Anderson, and McFarlane (2008) and Lundy and Janes (2009) published the two texts with the largest amount of ethical information; each text has 21 pages of content.

Overall, I noted a general increase over the years in the range of theories and amount of ethical content presented, based on yearly (1999–2012) comparisons of the texts. However, when different texts were examined by specific year, the content in texts was extremely variable; some texts represented a broad range of ethical principles, concepts, theories, and philosophies, while other texts published in the same year represented only selected and/or a limited amount of the same content.

Philosophies, Theories, and Concepts

Of the texts with ethical content, McMurray (2007) presented the fewest theories, addressing ethical issues only in relation to globalization. Stanhope et al. (2011, *Canadian*) discussed 16 ethical theories, with an addition of three theories, and the removal of one over their 2008 edition of the text. Similarly, the, Stanhope and Lancaster, (2012, *American*) addressed 11 theories. Stanhope, Lancaster, Jessup-Falcioni, and Viverais-Dresler (2011, *Canadian*) addressed the following theories: the four health care ethics principles, virtue ethics, feminist ethics, advocacy ethics, deontology, ethic of care, utilitarianism, rights-based theories, communitarian, and consequentialist theories, as well as the concepts of equality and/or equity. Stanhope et al. (2008, *Canadian*) did not include advocacy ethics, ethic of care, and equality or

equity; however, they did include discussion of ethics in relation to globalization, which was removed in the later edition.

Included in the text analysis were two text titles written by Stanhope and Lancaster, *Foundations of Nursing in the Community: Community-Oriented Practice* (2005 and 2010, *American*), and *Public Health Nursing: Population-centered Healthcare in the Community* (2008 and 2012, *American*). Stanhope and Lancaster (2005 and 2010, *American*) discussed the same theories and principles as Stanhope et al. (2011, *Canadian),* except in the American texts there was an addition of utilitarianism, and no discussion on general rights-based theory, equality or equity, women's moral experiences, and moral character. Stanhope and Lancaster (2008 and 2012, *American*) discussed many of the same theories and principles as Stanhope et al. (2011, *Canadian*). The 2012 American edition does not include a discussion on virtue ethics, and general rights-based theory. The Canadian version of Stanhope et al. (2008 and 2011, *Canadian*) was written and edited by Stanhope, Lancaster, Jessup-Falcioni, and Viverais-Dresler, whereas the American versions of Stanhope and Lancaster (2005 and 2010, *American*) and Stanhope and Lancaster (2008 and 2012, *American*) were edited by Stanhope and Lancaster and the ethics chapters were written by Silva, Fletcher, and Sorrell (2005, 2008, and 2010) and by Silva, Sorrell, and Fletcher (2012). In the American texts edited by Stanhope and Lancaster, even though the chapters are written by the same authors in each edition, the content was not consistently the same over the texts. Silva et al., in 2005 and 2010 (*American),* addressed the same principles and theories. However, compared to the 2008 edition of another text also written by Silva et al., they did not discuss virtue ethics, utilitarianism, and ethic of care, but additionally addressed rights-based theory, deontology, and consequentialist theory, even though the 2010 edition was published after the 2008 edition of another titled text. The 2012 American

text discussed similar theories as the 2010 American text, except virtue ethics and utilitarianism were removed. See Appendix C for further information.

Of all the texts analyzed, principlism was not mentioned at all in 11 of them. In 16 texts, principlism was discussed by the authors in terms of how the concepts were pertinent to public health. However, the texts did not establish a strong indication of relevance to public health and did not address the criticisms surrounding principlism and the application to public health—that foundationally principlism is individualistic. Ten of the 16 texts included the four tenets of principlism: autonomy, beneficence, non-maleficence, and justice; the remaining six texts included seven principles (an addition of three principles to the above mentioned four: veracity, fidelity, and respect for persons).

Stanhope and Lancaster presented a variety of ethical content in both their Canadian and American text editions. However, the texts' ethical content was presented without an indication of the implications and/or benefits for public health practice. The ethical theories presented were not applied or substantiated for public health practice. The variations of the content among the same authors in different editions, reinforces the observation of a lack of consistent information and ethical content available to public health professionals over a variety of texts, even when the authors remained consistent. The inconsistency of information over the texts leaves questions about why the authors made such variations. In my view, the textbooks would be better if they were more consistent and reflected a unified theory applicable to public health practice rather than providing an extensive list of ethical theories without consideration of the impact for public health practice. The inclusion of individualistic ethical theories within public health textbooks continues to support an individualistic perspective rather than a communitarian perspective on

public health ethics. This is reinforced by the inclusion of such theories as deontology and principlism.

Decision-Making Guidelines

Ethical decision making involves an orderly process that considers ethical principles, client values and abilities, and professional obligations, and it occurs when health care professionals must make decisions about ethical issues and ethical dilemmas (Stanhope et al., 2011, p. 166). Now that I have discussed the findings related to the principles, theories, and theoretical perspectives included in the various texts (above), I will move on to discussing the findings related to ethical decision making.

Researchers in 12 studies addressed ethical decision-making frameworks (see Appendix D). Stanhope et al. (2008, 2011, *Canadian*) and Stanhope and Lancaster (2005, 2010, 2008, 2012, *American*) are the only ones that addressed ethical decision-making frameworks over several editions (see Appendix E).

Stanhope et al. (2008 and 2011, *Canadian*) presented two ethical decision-making models: an *advocacy model* and a *generic model*. The advocacy model was presented in four texts and a generic model in five texts. Vollman et al. (2004) presented *Health Canada's Five Levels of Public Involvement Continuum*, and *Checklist for Public Participation Planning Process* in their first edition; surprisingly, they removed the ethical decision-making frameworks from their following editions (second and third editions). The removal of the ethical decision-making frameworks likely was a result of the difference in chapter authors, as noted previously. Vollman et al. introduced the frameworks. However, I concluded that the literature in Vollman's chapter did not support a thorough discussion of the frameworks on the significance to public health.

Uustal's seven-step process of valuing and values clarification was addressed in two editions of the texts written by Allender and colleagues: Allender and Spradley (2001) and Allender, Rector, and Warner (2010). Rector (2010), who wrote the ethics chapter in Allender et al (2010), stated that "underlying every issue and influencing every ethical and professional decision are values. Ethics and values are inextricably intertwined in professional decision-making, because values are the criteria by which decisions are made" (p.74). If, in fact, values underlie ethical decisions, I argue that it is important for public health nurses to explore and engage in value clarification, in order to determine where they stand ethically and enable themselves to understand where the individuals and communities with whom they engage stand.

A variety of other ethical decision-making frameworks were addressed throughout the 13 texts including: *Human Needs*(Anderson & McFarlane, 2008), Kass's (2001) *Six-Step Framework* (Lundy & Janes, 2009), *Problem-Solving Format* (Lundy & Janes, 2009), *Six Component Framework* (Hitchcock, Schubert & Thomas, 2003), *Uustal's Three Strategies* (Allender & Spradley, 2001; Allender et al., 2010), Thompson and Thompson's (1992) *Decision-Making Framework* (Allender & Spradley, 2001), *DECIDE Model* (Allender et al., 2010), *Iserson's (1999) Three Tests* (Allender et al., 2010), *Values Clarification* (Allender & Spradley, 2001; Allender et al., 2010), and *Dimensions Model* (Clark, 1999). The reader is referred to those specific texts for a description of these frameworks.

The wide variety of frameworks all have advantages and are applicable in particular circumstances; however, the disadvantage for the reader is determining which framework to use in particular circumstances. Narrowing down the frameworks for comparison and/or choosing one or two is a difficult task without losing an important step, factor, or concept. I would argue that, prior to one or two thorough and applicable frameworks being developed and created, a

consensus on a public health ethics needs to be agreed upon and/or established. None of the texts presented frameworks and compared and/or contrasted them to other available frameworks; rather the frameworks were simply introduced to the reader. The concern with introducing the theories, principles, and frameworks without relevance to public health, especially with an extensive available scholarship supporting individualistic perspectives leaves relevant community-centered perspectives weak and insubstantial.

Texts by Country

A general overview of the results was presented above; I will now take an opportunity to present the results based on the country the texts were published in. Theories and frameworks from texts published in the United Kingdom and Australia, the United States, and Canada will be discussed under subsequent subheadings, followed by an additional subheading addressing the *Community as Partner* texts. Diem and Moyer (2005) and Stewart (2000) did not provide any ethical information and therefore will not be included in the review below.

United Kingdom and Australia. Three texts addressed content from both the United Kingdom and Australia. Watkins, Edwards, and Gastrell (2003), a UK-based text, addressed the following: philosophies of deontology, utilitarianism, and four necessary themes (respect for persons, consent, accountability, and advocacy). Watkins et al.'s text also included an advocacy framework, including both a conceptual and practical approach.

The Australian-based texts were written by McMurray in 1999 and 2007. McMurray (1999) addressed cultures, social justice, and the concept of principlism with a focus on justice. McMurray (2007) focused on globalization with no direct connection to specific ethical theories that are, or need to be, utilized by public health nurses.

The authors of the UK and Australian texts did not address many of the above-mentioned theories, and only focused on the advocacy framework for decision making. The information presented was not only limited in what was presented but did not address pertinent theories that public health nurses could apply in practice, such as the communitarian theories, specifically relational ethics.

United States. Several texts were analyzed that were published within the United States of America (U.S.). Hitchcock et al. (2003) focused their text's ethics content on autonomy, principlism, deontology, teleology, utilitarianism. As for decision-making frameworks they also discussed a generic decision-making model and the six-component framework for decision making (Hitchcock et al., 2003). The latter comprises the following steps/components: determining involvement, gathering data, outlining options and consequences, process for resolving conflict, planning for actions/implementation, and evaluation.

Clark (1999) defined multiple principles and theories and discussed assessing the layers of the ethical dilemma that public health nurses face. Principlism, virtue ethics, rule ethics, deontology, ethic of care, utilitarianism, rights-based, communitarianism, and consequence-based ethical theories were discussed in Clark's text. Additionally, Clark stated the importance of including an evaluation step; however, no elaboration with regards to an evaluation was discussed.

Allender and Spradley (2001) wrote *Community Health Nursing: Concepts and Practice* (fifth edition), and Allender, Rector, and Warner (2010) wrote *Community Health Nursing: Promoting and Protecting the Public's Health* (seventh edition). The fifth edition (2001) discussed a few ethical decision-making frameworks including: Three key steps to choosing alternative actions; Thompson and Thompson's (1992) decision-making framework; a couple of

generic decision-making frameworks; and Uustal's (1977) seven-step process of valuing. Allender and Spradley (2001) also discussed the intent of the frameworks. Allender et al. (2010) combined the ethics chapter with content on types of research and the process for conducting research. Included in the seventh edition was: Three key steps to choosing alternative actions; DECIDE model (Thompson, Melia, and Boyd, 2000 as cited in Allender et al., 2010); Iserson's (1999) three tests (impartiality test, universalizablity test, and interpersonal justifiability test); and a list of basic values that guide decision-making (self-determination, well-being, and equity). Allender et al. (2010) covered four decision-making frameworks; only one framework (the three key steps to choosing alternative actions) overlapped from the 2001 (fifth) and 2010 (seventh) editions. However, there was no discussion on the philosophies, theories, and principles that public health nurses draw on in everyday ethical practice.

Lundy and Janes (2009) discussed virtue ethics, utilitarianism, deontology, principlism, communitarian ethics, and ethic of care. A case study applying a deontological, utilitarian, and caring approach also was included. Lundy and Janes (2009), as well as Stanhope and Lancaster (*American*), discussed community-based ethical theory, which did not include a discussion on relational ethics. Community-based ethical theory is a generic descriptor for a range of theories that relate to community health and were derived from mutual values, goods, goals, and cooperative virtues (Callahan, 2003; Etzioni, 2010; Kelley, 1992; and Sutrop, 2011).

Stanhope and Lancaster published *Foundations of Nursing in the Community: Community-Oriented Practice*; the second (2005, *American*) and third (2010, *American*) editions of this text were analyzed for this paper. No changes to the ethics content were made to the third edition from the second. Stanhope and Lancaster's second (2005) and third (2010) text editions discussed the same theories as Lundy and Janes (2009) with the addition of feminist

ethics. The text included a discussion on a generic ethical decision-making framework consisting of a seven-step process. There was a further discussion of an advocacy framework, with both a conceptual and a practical approach (as discussed in the text above).

Stanhope and Lancaster (*American)* published an additional set of texts, two of which were used in the analysis for this paper: *Public Health Nursing: Population-centered Healthcare in the Community,* the seventh (2008) and eighth (2012) editions. In these editions, multiple theories and concepts were brought to the readers' attention, including those discussed by Lundy and Janes (2009) and Stanhope et al. (2005 and 2010), with the addition of respect for autonomy, rights-based ethical theory, consequence-based ethical theory, obligation-based ethical theory, nursing code of ethics, advocacy, justice, health policy, and caring.

A particular concern I noted through this analysis was the variance in terminology used in categorizing and/or discussing theoretical perspectives. A rights-based ethical theory can refer to the deontological perspective with regards to the rightness of action or duty of action. A rights-based ethical theory can also refer to human rights referring to an individual's rights. Consequence-based theory refers to consequential perspectives, including utilitarianism. Obligation-based can refer to a deontological perspective as well, based on the obligation of duty. It is imperative that nurse scholars use consistent terminology to avoid confusion and to ground nursing education as foundational knowledge for practice. The texts also included a brief discussion on a generic ethical decision-making framework, including the rationale for the steps and the conceptual and practical frameworks for advocacy, which were unchanged from Stanhope and Lancaster's second (2005) and third (2010) editions.

Canadian. The majority of the texts analyzed contained American content; the texts specifically written with a Canadian focus are relevant for Canadian nurses in applying the

examples, situations, and statistical data to practice. Of the texts compared, 10 contained Canadian content, and four of those were revised editions of the texts: Stanhope et al. (2008, 2011, *Canadian*), Stamler and Yiu (2005, 2008, 2012), and Vollman et al. (2008, 2012). Texts by Vollman et al. will be discussed under a separate subheading below, because it will be compared to the American version of the text.

Stanhope et al. (2008, *Canadian*) discussed a variety of ethical theories and concepts which are identical to Stanhope and Lancaster's 2008 (seventh, *American*) and 2012 (eighth, *American*) editions. Stanhope et al. (2011, *Canadian*) included equity and equality, as well as provided a definition of Upshur's (2002) principles (harm principle, principle of least restrictive means, reciprocity principle, and transparency principle). However, Stanhope et al.'s second edition (2011, *Canadian*) does not present Upshur's (2002) principles beyond a definition. Upshur's (2002) principles were not applied to practice and were not discussed for the importance of their principles to public health. Neither edition provided discussion of relational ethics as a communitarian theory. Further, Stanhope et al., in both Canadian editions (2008 and 2011), and Stanhope and Lancaster in the American editions (2005, 2008, 2010, and 2012) presented a generic ethical decision-making framework and conceptual and practical frameworks for advocacy. However, both the Canadian and American editions only presented the frameworks, but did not compare or contrast them.

Stamler and Yiu mentioned relational autonomy but did not discuss relational ethics. Stamler and Yiu's first edition (2005) focused on feminist bioethics as the theory relevant to community health and public health; however, they failed to discuss any other relevant ethical theory and did not include a discussion on ethical decision-making frameworks. Stamler and Yiu's second (2008) text edition included definitions of human rights, equity, and advocacy, as

well as a discussion on Upshur's (2002) four ethical principles. Further, Stamler and Yiu's third edition (2012) offered only subtle changes from the previous edition. Stamler and Yiu's second (2008) and third (2012) editions included a mention of relational autonomy, but no elaboration was provided and it was not discussed more broadly within the context of relational or public health ethics.

Stanhope et al. (2008 and 2011, *Canadian*), Lundy and Janes (2009), Stanhope and Lancaster (2005 and 2010, *American*), and Stanhope and Lancaster (2008 and 2012, *American*) addressed communitarian ethical theories as part of or in combination with feminist ethics. Overall, Stanhope and Lancaster (2005, 2008, 2010, and 2012, *American)* and Stanhope et al. (2008 and 2011, *Canadian*) had a more consistent ethical content amongst text editions as compared to other American and Canadian texts analysed. However, relational ethics was not addressed by any of these texts.

Community as Partner. *Community as Partner* has both Canadian and American versions of the texts with multiple editions. Anderson and McFarlane were editors of both the Canadian and American texts, and Vollman was the primary editor of the Canadian version.

The American versions of *Community as Partner* that were analyzed included the second edition (1996, *American*), third edition (2000, *American*), and fifth edition (2008, *American*). The authors of the second (1996) and third (2000) editions discussed universalism versus advocacy, stating that universalism places the professional as expert and that advocacy considered the professional and community in a partnership role. Anderson and McFarlane (1996 and 2000, *American*) stated that values and choices needed to be a part of the advocacy approach. The second (1996, *American*) and third (2000, *American*) editions included discussion on the implications of both universalism and advocacy on community health. The fifth edition

(2008, *American)* suggested that the most helpful approach for public health is a focus on both deontology and teleology. As noted above, terminology is particularly important for the nursing profession for communication and comprehension of knowledge which is foundational to practice. New terminology used and unique ideas and concepts provides an opportunity for development of a weak knowledge base for public health nurses to practice on, rather than providing clarity and competence for practice.

The Canadian versions of *Community as Partner* I analyzed included the first edition (2004), second edition (2008), and third edition (2012). Vollman, Anderson, and McFarlane (2004, *Canadian)* discussed the four bioethics principles, advocacy, and social justice and mentioned Coughlin et al.'s (1997)10 moral rules for public health: don't kill, don't cause pain, don't disable, don't deprive of freedom, don't deprive of pleasure, don't deceive, keep your promise, don't cheat, obey the law, and do your duty (p. 108). These rules were presented as moral rules that are well known and established in community health nursing and yet are not discussed in any other community health nursing texts. In fact, Vollman et al.'s first edition (2004, *Canadian*) listed Coughlin and coworkers' (1997) moral rules but they do not discuss them. Further, Vollman et al.'s second (2008,*Canadian)* and third (2012, *Canadian)* editions removed the 10 moral rules noted in the 2004 edition (*Canadian),* likely resulting from the change in chapter authors between editions. The first edition (2004, *Canadian*) also presented Health Canada's five levels of public involvement continuum as a process for public health action. The second (2008, *Canadian*) and third (2012, *Canadian*) editions focused on rule (teleology and deontology), virtue, and feminist ethics; the authors stated that those are the primary theories in community health. Further, these two editions (2008 and 2012, *Canadian)* provide a critique of these ethical theories related to community health. Finally, the authors

included a list of seven concepts foundational to public health: “inclusion, diversity, participation, empowerment, social justice, advocacy, and interdependence” (Racher, 2012, p. 35).

The American and Canadian versions of *Community as Partner* are not comparable; rather, the content of the texts differed considerably in their focus. Perhaps the difference in the content is a result of the difference in the health care systems and in the organization and structure of public health between the two countries. However, both countries’ versions of the texts make it apparent that the content is not unified across the public health profession, even with two of the editors being the same. As noted earlier, Vollman wrote the ethics chapter in the 2004 edition *(Canadian),* whereas Racher wrote the ethics chapter in the 2008 and 2012 editions *(Canadian)*. As with the Canadian editions of the text, the American version has different authors for the ethics chapter, with Gadow and Schroeder writing the second edition (1996), then switching author order—Schroeder and Gadow for the third (2000) edition—and, finally, in the fifth (2008) edition the authors are changed altogether, the chapter written by Walker. The authors and thus the content varied considerably over the editions of both the Canadian and American text versions; the authors changed *between* the Canadian and American text, as well as *within* the editions.

Summary

The texts varied in the theories, philosophies, and concepts presented and placed emphasis on different aspects; the majority of the texts did discuss the importance of a communitarian ethics approach; however, utilitarianism and deontology seemed to be the philosophies that authors tended to promote. Zahner (2000) noted in her study that deontology was central to the theoretical content represented by 64% of textbooks in her analysis. She

further noted that a utilitarian perspective at that time was uncommon, with 14% of textbooks representing utilitarian content. Relational ethics was not mentioned in any of the texts in my analysis, apart from the mention of relational autonomy by Stamler and Yiu's texts; there was, however, discussion on other community-centered ethical theories, such as feminist ethics, and a select few texts mentioned relational autonomy. Public health is a community-centered profession; however, the relevant texts do not necessarily present much about community-centered ethical approaches. However, there is a noted shift from Zahner's (2000) study towards a more community based ethical principle approach.

Of the Canadian texts available for public health nurses to base their practice and decisions on, Stamler and Yiu's (2005, 2008, and 2012) text editions had major shortcomings in providing reliable and applicable ethical information. In part, this may be because the audience for the text included both home health and public health nurses. Traditional health care ethics content, with an individual focus, is more relevant for home care than for public health. What this means, however, is that the individually-focused ethics content is privileged in this important Canadian community health nursing text. Stanhope et al. (2008 and 2011) provided a well-rounded list of theories beneficial to public health nurses learning and understanding. Vollman, Anderson, and McFarlane (2004, 2008, and 2012) provide a well-rounded list of theories as well, and further include critiques of rule ethics, virtue ethics, and feminist ethics. None of the texts discuss relational ethics as a theory applicable to public health nursing; this may be a result of relational ethics as a new and emerging focus in the nursing and the public health nursing literature (MacDonald, 2013).

The inconsistency of authors over the many texts and text editions likely resulted in the differing public health ethics and decision-making framework content. The concern with the

difference in ethical content amongst public health and community health textbooks is the consistency and dependability of the information available for public health nurses to base their individual practice on. The variation of ideals noted by the authors within the textbooks leaves questions for the practicing professional on which information to ground their practice. The ethical content presented in the textbooks that were analysed in my project did not balance the care of the community and individuals -- rather one was privileged. The ethical content presented in the textbooks provided a large spectrum for individual interpretation and for theoretical application. A communitarian ethical approach, namely relational ethics would address this concern, as an individual or community is not privileged over the other, rather there is an attempt at a balance.

Limitations and Implications

This project had a few noted limitations as well as implications. The first limitation was that the textbooks analyzed were in the English language and did not include any French language textbooks. Given that Canada is a bilingual country, the relevance of this analysis for francophones is limited. The second limitation was that the textbooks analyzed were selected because they were written specifically for public health and/or community health. Other texts written specifically on ethics may have contained information on public health ethics. For example, a recently published nursing ethics text by Storch, Rodney and Starzomski (2013) contained chapters by MacDonald (2013) and Pauly (2013) that were specifically relevant to public health nursing. These types of texts were not explored because they were not specifically aimed at public health practitioners. Despite the noted limitations, my project did provide important information with regards to the current information available on public health ethics for public health nurses, within community or public health nursing textbooks. I do not foresee

any long-term negative consequences resulting from this paper; rather, I see the benefit being a recognition of the need for the profession to agree on the relevant ethical theories to guide public health practice.

Discussion

The analysis indicates that there continues to be a knowledge gap and lack of a cohesive understanding about the meaning of public health ethics and how it is relevant for public health nursing. No one textbook analyzed provided a clear answer to the meaning of public health ethics. Currently, no community/public health nursing textbook sources commonly utilized in Canadian nursing education provide thorough elaboration on all available principles, concepts, philosophies, and theories relevant to public health ethics. This paper postulates the same through this analysis. Some texts incorporate a broad range of theories available for use by public health professionals, specifically nurses, and do show progression over time in the understanding of and knowledge about public health ethics. The analysis also indicates that some of the authors place more importance on certain theories than on others, as demonstrated by either the inclusion and/or exclusion of specific theories. The textbook analysis indicates that there is limited or nonexistent discussion on ethical decision-making frameworks in some texts. It further indicates that although there has been a progression in the broader literature related to public health ethics, much more work still has to be done to bring the understanding of public health ethics to the forefront for public health nurses to base their practices upon. Furthermore, there is a great need for a cohesive understanding of what public health ethics entails and practical decision-making models that public health nurses can utilize to make ethical decisions.

The definition of public health is clear, as are the goals and purpose of public health's agenda for the health and well-being of the community and population. What is not clear, and

where the knowledge needs further refinement and development, is in the ethical philosophy and theory that public health professionals, including public health nurses, should engage with and be guided by in practice. The challenge presented to public health nurses is to determine what set of values public health nurses will hold as being important to the core of their practice. Included in this challenge is having public health nurses come together as a collective and unified profession with a shared understanding, and developing appropriate ethical frameworks to guide practice.

This project identifies a continued gap in knowledge and understanding of public health ethics as presented in public/community health nursing textbooks, and points to a need for further academic scholarship in this area of health care. The gap in knowledge exists around a collective understanding and agreement on an ethics. Public health nurse educators will need to develop their scholarship in this area in order to fill in the gaps and develop a public health ethics theory *in* and *for* public health nurses to support and facilitate a cohesive practice. Relational ethics is an ethical theory able to address public health goals from a community perspective while balancing individual care, and needs further exploration and application within public health from a collective perspective, rather than from a select number of scholars. Thorne, Best, Balon, Kelner, and Rickhi (2002) stated that "ethics, or the study of how we might determine morally correct action under various circumstances, requires some consensus or agreement as to how we will be able to know the greater individual or social good" (p. 908).

The information presented in the texts contains valuable insight, but the majority of the texts were limited in providing comprehensive ethical theoretical content. Stanhope et al. (2011, *Canadian*) provided the widest range of ethical theories in their second edition text, which included a discussion on community-based ethical theory. The same cannot be said for ethical decision-making frameworks; ultimately, Stanhope et al. (2011) did not provide enough content.

Education utilizing this specific text would require additional supplemental information to address this gap. The text with the most decision-making frameworks is a seventh edition text published by Allender et al. (2010), however, the authors did not provide a relevant list of frameworks that can be utilized by professionals. Allender et al. (2010) offered the public health nursing profession a resource with the widest variety of frameworks to rely on; the frameworks help address a variety of ethical concerns when faced with obstacles in practice.

Other useful frameworks that potentially may be of use by public health professionals in making ethical decisions for practice include: Health Canada's five levels of public involvement continuum, checklist for public participation planning process, advocacy model, paternalism, contractualism, consumerism, human needs, Kass's (2001) six-step framework, problem-solving format, six-component framework, Thompson and Thompson's (1992) decision-making framework, and the dimensions model. The range of frameworks is useful in attending to a variety of concerns that public health professionals may face in practice; the frameworks all are beneficial to the public health profession to address a range of diverse ethical concerns/barriers. The aforementioned decision-making models are a summary of the frameworks mentioned in the analyzed texts. However, supplemental material is needed that discusses the different decision-making frameworks when teaching and learning about the frameworks for public health.

Conclusion

Textbooks are only one mode of educational information; in the present education system, learners use a variety of methods, including debates, discussion, group activities, articles, lived experience, media, and of course, practice. It is important to note that learning and knowledge will need to be reinforced and taken to the next level with supplemental information from other sources, such as recent journal articles.

Learners may be accessing programs developed for public health and may be engaged with public health ethics content; however, not all of these programs are accessible by frontline public health professionals, and/or considered necessary by them or mandatory by their employers. Public health education, including public health ethical education, needs to be clear, accessible (feasible), and understandable to provide public health professionals with a cohesive understanding and knowledge base in order to build a concise and transparent public health profession.

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Appendix A: Textbook Reference List

In the textbook reference list, I identify the textbooks analyzed for the project. The textbooks in this section are listed in alphabetical order by book title and then sorted chronologically by text edition.

Vollman, A. R., Anderson, E. T., & McFarlane, J. (2004). Ethics and advocacy in community practice. In A. R. Vollman, E. T. Anderson, J. McFarlane (1st ed.), *Canadian community as partner: Theory and multidisciplinary practice* (pp. 106–123). Philadelphia, PA: Lippincott Williams & Wilkins.

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Appendix B: Framework

Textbook Author(s)/ Editor(s)	Chapter Author(s)	Year	Textbook Title	Edition	# of pages	Overall % of coverage **page numbers noted up until index**	Theory/Theories addressed	Frameworks addressed	Changes/ progression over editions	Discussion of ethics theory/concept	Implications to and ethical challenges within public health	Additional comments/notes
Vollman, A. R., Anderson, E.T., & McFarlane, J.	Vollman, A. R., Anderson, E. T., & McFarlane, J.	2004	Canadian Community as Partner: Theory and Multidisciplinary Practice	1st	17	3.6%	Defines ethics. Discusses four ethical principles (beneficence, nonmaleficence, justice, and autonomy); further elaborates on the justice principle (distributive justice: egalitarian, libertarian, and utilitarian).	Discusses Health Canada's (2000) five levels of public involvement continuum (for public involvement in decision-making) and also presents a checklist for the public participation planning process (preparation, design, implementation, synthesis, feedback and follow-up, and evaluation).		Mentions Coughlin and coworkers' (1997) 10 moral rules ("don't kill, don't cause pain, don't disable, don't deprive of freedom, don't deprive of pleasure, don't deceive, keep your promise, don't cheat, obey the law, and do your duty"). However, the chapter does not discuss beyond mentioning the 10 moral rules. Authors do mention and briefly discuss in table format Clark's (2000) four societal factors that can place values in conflict (factors, questions, and examples).	Discusses obstacles to implementation s of effective community empowerment strategies as presented by Israel and colleagues (1994) and then further presents Bracht's (1990) factors for success to overcome obstacles and barriers through process and effective communication .	Discusses Oberle and Tenove's (2000) five themes of ethical problems that face community nurses (relationships with health care professionals, systems issues, character of relationships with the community client/partner, respect for persons, and putting self at risk).

Textbook Author(s)/ Editor(s)	Chapter Author(s)	Year	Textbook Title	Edition	# of pages	Overall % of coverage **page numbers noted up until index**	Theory/Theories addressed	Frameworks addressed	Changes/ progression over editions	Discussion of ethics theory/concept	Implications to and ethical challenges within public health	Additional comments/notes
Vollman, A. R., Anderson, E.T., & McFarlane, J.	Racher, F. E.	2008	Canadian Community as Partner: Theory and Multidisciplinary Practice	2nd	21	3.9%	Ethical pluralism vs. Ethical relativism, rule ethics (teleology and deontology), virtue ethics, feminist ethics, ethical foundations of public health and community practice, ethical challenges, advocacy.			Discussed: advocacy; difference between values, principles, ethical principles, and virtues; practical ethics, professional ethics, and bioethics; (suggested) three ethical concepts of primary concern in community health—rule ethics, virtue ethics, and feminist ethics; discussed principles (autonomy, beneficence, non-maleficence, justice, respect for persons, sanctity of life, fidelity, and veracity); seven foundational ethical concepts of public health—inclusion, diversity, participation, empowerment, social justice, advocacy, and interdependence; public health code of ethics.	Discusses some ethical challenges faced within community practice; and discusses and critiques rule, virtue, and feminist ethics.	This chapter critiqued rule ethics, virtue ethics, and feminist ethics in relation to public health. Discussed the public health code of ethics - however referred to the American Public Health Association, rather than providing information from a Canadian perspective and/or lens. The chapter does reflect a section on the Ottawa Charter of Health Promotion and presents it as a statement of values and moral commitment.

Textbook Author(s)/ Editor(s)	Chapter Author(s)	Year	Textbook Title	Edition	# of pages	Overall % of coverage **page numbers noted up until index**	Theory/Theories addressed	Frameworks addressed	Changes/ progression over editions	Discussion of ethics theory/concept	Implications to and ethical challenges within public health	Additional comments/notes
Vollman, A. R., Anderson, E.T., & McFarlane, J.	Racher, F. E.	2012	Canadian Community as Partner: Theory and Multidisciplinary Practice	3rd	17	3.6%			Removed paragraph defending teleology and deontology. Removed table 2-1 "Historical development of Rule Ethics." Overall content the same in newest edition as compared to previous edition.			Chapter outline and learning objectives the same as previous edition. Overall page # of text decreased and the number of pages decreased from 21 to 17 in ethical content. Sentence structure changes, content the same.

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Anderson, E.T., & McFarlane, J.M.	Gadow, S. & Schroeder, C.	1996	Community as Partner: Theory and Practice in Nursing	2nd	14	3.0%	Universalism vs. Advocacy.	Presents advocacy as an ethical framework. "An advocacy model of community health returns power to communities through partnerships of professionals and representatives of all members of a community. Through partnership, professionals and communities develop a health narrative that expresses the diverse values of the community regarding health. Unique and nongeneralizable, the narrative guides service delivery and reform within the community that participated in its development as partner" (p.136).				This chapter outlines the objectives. Content is based on United States data/practice and not Canadian.

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Anderson, E.T., & McFarlane, J.M.	Schroeder, C., & Gadow, S.	2000	Community as Partner: Theory and Practice in Nursing	3rd	13	3.1%			Not updated from 2nd edition. Only sentence structure changes and editing. No new content and/or progression.			

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Anderson, E.T., & McFarlane, J.M.	Walker, S. S.	2008	Community as Partner: Theory and Practice in Nursing	5th	14	3.0%	Defines what ethics is. Discusses contrasts ethics with laws. Discusses applied ethics (deontology and teleology). Discusses advocacy and catalyst as roles of health care professionals. Discusses 7 principles in health care ethics (autonomy, respect for persons, beneficence, non maleficence, justice—distributive and retributive, veracity, and fidelity).	Discusses traditional: paternalism, contractualism, and consumerism as frameworks for health care roles. Discusses the human needs framework as a method to evaluate the merit of the choice of action (physiological needs, safety, belonging, self-esteem, and self-fulfillment).	Focuses on the 7 primary principles and none of the other ethical theories. Gadow and Schroeder's advocacy ethics is not discussed.	States "application of ethics to health care decision making usually involves a combination of these two approaches" (p. 76) referring to deontology and teleology.	Discusses in-depth the 7 principles of health care ethics and the conflicts between and among the principles.	

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McMurray, A.	McMurray, A.	1999	Community Health and Wellness: A Socio-ecological Approach	1st	12	3.0%	Discusses cultures. Discusses the ethics principles (autonomy, beneficence, nonmalficence, and justice). Discusses ethical dilemmas around genetic engineering. Discusses ethical concerns around health promotion. Discusses in a later chapter research ethics.			Questions such things as: "To what extent, then, to we impose goals on the convictions of another's culture?" Poses the question, however, does not provide a variety of theories to contemplate. Only leaves the reader pondering the question, with the ethics principle. Discusses briefly the principles (autonomy, beneficence, non maleficence, and justice. Discusses the principle of justice in-depth. Doesn't elaborate on the other principles and does not discuss many of the other ethical theories. Elaborates on defining the justice principle: Distributive justice, egalitarian justice, and restorative justice. Discusses genetic engineering and the ethical dilemmas present, however does not elaborate on actual theory. Discusses ethical concerns around health promotion.		

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McMurray, A.	McMurray, A.	2007	Community Health and Wellness: A Socio-ecological Approach	3rd	5	1.2%	Discussed globalisation. Did not discuss any specific ethical theories. The text also addresses ethical content on research ethics and how to maintain an ethical stance when conducting a research study rather than on everyday practice.					Author stresses the importance of changing language of the 1980s to the "first language of public health"—egalitarianism, humanitarianism, and human interconnection. However, the author fails to define and directly apply the theory to public health practice in the text.

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Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2008	Community Health Nursing in Canada	1st	19	3.5%	Discussed autonomy, rights-based ethical theory, community-based ethical theory, consequence-based ethical theory, obligation-based ethical theory, advocacy, justice (egalitarianism, libertarian, and liberal democratic), health policy, caring, women's moral experiences, moral character of health care practitioners, codes of ethics, and ethical decision-making frameworks. Discussed utilitarianism, deontology, principlism, virtue	General ethical decision-making framework steps and rationale were outlined. Conceptual framework for advocacy presented (information stage, strategy stage, and action stage). Practical framework for advocacy presented (referring to six ethical principles for effective advocacy—p.119).		Ethics was defined. General obligations that humans have to members of society were listed (to not harm others, to respect others, to tell the truth, and to keep promises). The cons are listed for the ethical principles, however the cons/implications are not listed for utilitarianism and/or deontology; states why other theories may be more practical however appears to be biased if it is only presenting one side of a theoretical theory's purpose and/or potential. Discusses communitarianism in depth (virtue ethics, ethic of care, and feminist ethics). Discusses the nursing code of ethics, including the Canadian (CNA) code of ethics for registered nurses; summary of values and responsibility statement also listed. Determinants of health are referred to within the chapter and readers are redirected to		Chapter outlined objectives, chapter outline, and key terms were listed with corresponding page #. Canadian content and Canadian practice reflections. How to boxes were used to help apply ethical principles to decision making process; only critique is the boxes could have been more beneficial had an example been used as without an example the boxes may present more as a barrier to learning without an example and to students learning the theory and applying it to practice (situations in which they may not have been

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							ethics, ethic of care, and feminist ethics.			chapter 1 of text for further reading/understanding.		exposed to) may be a deterrent to learning. Case studies at the end of the chapter available to reinforce learning with answers.
Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2011	Community Health Nursing in Canada	2nd	20	3.0%	Discusses consequence-based ethical theory, obligation-based ethical theory, advocacy, justice, health policy, caring, women's moral experiences, moral character of health care practitioners, code of ethics, ethical decision-making	General ethical decision-making framework steps and rationale were outlined.	New content: principles for the justification of PH intervention; equality; equity; social justice. Lost: informed consent. Minor revisions to sentence structures, and updated references.	Discussion of ethical theory content similar with updates to previous editions theory, added content on equality, equity, social justice, and Upshur's (2002) principles. Upshur's principles are briefly defined and not elaborated on.		Outlines objectives, chapter outline, and key terms. Discusses CNA code of ethics relevant to Canadian nursing practice, rather than US. Examples used reflect Canadian health care system. Canadian content and practice reflections. How to boxes to help apply

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							frameworks.		Code of ethics table (4-2: Summary of the Values & Responsibility Statements) has been removed. Case studies updated. Upshur's (2002) principles added to the content (harm principle, principle of lease restrictive means, reciprocity principle, and transparency principle).			ethical principles to decision making process; only critique is the boxes could have been more beneficial had an example been used; without an example the boxes may present more as a barrier to learning the theory and applying it to practice (in situations students may not have been exposed to) may be a deterrent to learning. Case studies at the end of the chapter reinforce learning with answers.
Diem, E. & Moyer, A.	Diem, E. & Moyer, A.	2005	Community health nursing projects: Making a difference	------	0	0.0%						

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Stamler, L.L. & Yiu, L.	Peter, E., Sweatman, L., & Carlin, K.	2005	Community Health Nursing: A Canadian Perspective	1st	15	4.0%	Central values of Canadian nursing: safe competent ethical care, health and well-being, choice, dignity, confidentiality, justice, accountability, and quality practice environment. Defines terms of Canadian nursing central values (as per CNA).			Central values of Canadian nursing: safe competent ethical care, health and well-being, choice, dignity, confidentiality, justice, accountability, and quality practice environment. Defines terms of Canadian nursing central values (as per CNA). Doesn't discuss the multiple existing theories. Instead focuses on feminist bioethics, the CNA code of ethics and CHN standards of practice. CHN standards of practice discussed (1. promoting health, 2. building individual/ community capacity, 3. building relationships, 4. facilitating access and equity, 5. demonstrating professional responsibility and accountability).		Key terms, study questions, individual critical thinking questions, and group critical thinking questions

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Stamler, L.L. & Yiu, L.	Peter, E., Sweatman, L., & Carlin, K.	2008	Community Health Nursing: A Canadian Perspective	2nd	14	3.4%			Added "Advocacy" to chapter title. Updated objectives. CNA central values listed in a table, definitions removed. Same content; slight sentence & word changes. Updated social justice content. Added social justice and ten attributes as a desired result or end (table format with definitions). Added Upshur's (2002) four ethical principles (1. harm principle, 2. least restrictive or coercive means, 3. reciprocity, and 4. transparency).	Focuses on feminist ethics, CNA code of ethics, and CHN standards of practice. Does not define or discuss the multiple other existing theories.		

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									Community settings as sites of care updated.			

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Stamler, L.L. & Yiu, L.	Peter, E., Sweatman, L., & Carlin, K.	2012	Community Health Nursing: A Canadian Perspective	3rd	14	2.6%			Removed feminist ethics from objectives. Table 4.1 updated & changed—quoted "Quality practice environments" removed. Added sentences below listed ethical responsibilities. Overall content the same, sentence structure changes. Removed name "Feminist bioethics" grouped under social justice. No ethic of care, rather changed it to everyday ethics. References added to tables, and some reference updates.			Objectives clearly outlined. Increase in overall number of pages in text, however same number of pages for the chapter.

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Clark, M.J.		2008	Community health nursing: Advocacy for population health	5th	0	0%						
Clark, M.J.		2003	Community health nursing: Caring for populations	4th	0	0%						

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Lundy, K. S. & Janes, S.	Kurtz, P. & Burr, R. I.	2009	Community health nursing: Caring for the public's health	2nd	21	1.9%	Virtue ethics, principle-based ethics (autonomy, benevolence, nonmaleficence, and justice), utilitarian, deontology, justice, ethic of care, communitarian ethics, values and health policy, and ethical decision making.	Discusses/presents a decision-making framework based on a "problem-solving format" consisting of five steps. Presents Kass's (2001) six-step framework "for public health and aggregate populations that poses questions to be asked of program developers."		Defines ethics and bioethics. Defines and discusses virtue ethics, and discusses Beauchamp and Childress's (1994) four virtues—compassion, discernment, trustworthiness, and integrity. Discusses Utilitarianism and deontology. Discusses the American Nurses Association Code of Ethics. Discusses principles (autonomy, benevolence, nonmaleficence, and justice). Discusses communitarian ethics. Discusses values and health policy. Discusses ethic of care. Presents information/research on ethical problems faced by community health nurses and then provides a few ethical decision making frameworks.		Outlines ch. focus, questions to consider, & key terms. Includes Ethical Connection boxes provide a place for readers to apply content to examples. Environmental Connection relations environmental issues to the effects on the communities' health. Cultural Connection explores cultural beliefs impact on public health, as well as provides a place for self-reflection. Good Read section provides information for readers for further readings. Application to Practice sections are case studies. Critical Thinking Activities questions posed to readers/learners to critically think & apply content. Got an Alternative provides alternative method for dealing with preventing and healing illness and disease; provides another look from another perspective. Content is U.S. based not Canadian

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												content/examples.
Hitchcock, J.E., Schubert, P.E., & Thomas, S.A.	Case, N. K.	2003	Community Health Nursing: Caring in Action	2nd	20	2.2%	Case (2003) states "basic theories and principles provide universal guidelines for an underlying approach to ethical issues regardless of the setting for healthcare" (p. 142). In the chapter, Case discusses deontology and utilitarianism, then further compares the two with the same situation providing an understanding of the difference between the theories within the same practice example. He discusses ethical principles (beneficence,			Discusses ethical codes (ANA and international nurses code, however does not address the Canadian code).	Discusses six components that are essential to adequately address ethical dilemmas: determining involvement, gathering data, outlining options and consequences, process for resolving conflict, planning for action or implementation and evaluation.	This chapter lists the competencies to be achieved following completion of the chapter, and the key terms are listed. The content concentrates on the United States and not Canadian practice. The chapter presents "decision making" boxes and "reflective thinking" boxes posing questions to engage readers into thinking and applying the theories.

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							nonmaleficence, justice, and autonomy, and presents ethical rules of fidelity, veracity, and accountability. Slightly touched on are feminist approach and caring approach but not addressed in depth. Discusses values and ethical codes.					
Allender, J.A. & Spradley, B.W.	Spradley, B. W. & Allender, J. A.	2001	Community Health Nursing: Concepts and Practice	5th	13	1.7%	Discusses autonomy, beneficence, distributive justice, egalitarian justice, equity, ethical decision-making, ethical dilemma, ethics, fidelity, instrumental values, justice, moral, moral evaluations,	Discusses process of valuing (Uustal, 1997—seven steps). Discusses 3 distinctive characteristics that moral evaluations entail. Discusses decision-making frameworks to resolve ethical dilemmas: the need of considering three fundamental steps in choosing an alternative course of action: 1. separate questions of fact from questions of value; 2. identify both clients' and		Discuses the five qualities of values: endurance, hierarchical arrangement, prescriptive-proscriptive belief, reference, and preference. Discusses the difference between values and ethics and elaborates on each. Discusses the seven fundamental ethical principles: respect, autonomy, beneficence, nonmaleficence, justice, veracity, and fidelity. Discusses the ANA code of		Ch lists the learning objectives & key terms outlined. Text refers to United States and not Canadian practice. Content presented includes statistics which aren't relevant to Canadian practice as the stats shown reflect practice, demographics, and

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							nonmaleficence, respect, restorative justice, self-determination, self-interest, terminal values, value, value systems, values clarification, veracity, and well-being.	nurse's value systems; 3. consider ethical principles and concepts. Thompson & Thompson's (1992) decision-making framework Thompson & Thompson's framework according to the authors "advocates keeping multiple values in tension before resolution of conflict and action on the part of the nurse. It suggests that value conflict is not capable of resolution until all possible alternative actions have been explored" (p. 86). "Three basic human values are considered key to guiding decision-making in the provider-client relationship and can be used with the framework of Thompson and Thompson (1992): self-determination, well-being, and equity (Davis and Aroskar, 1997; President's Commission for the Study of Ethical Problems, in Medicine and Biomedical and		ethics and not the Canadian code of ethics.		situations within the US rather than that of the Canadian Health care system. Ethical content does not discuss all of the theories used within the public health practice area extensively; background and general work up very thorough, however ethical theory content limited and narrow focused. The text limits the readers understanding of other ethical theories. Not only does it not elaborate/provide detail but it does not address all of the available theories.

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								Behavioural Research (President's Commission), 1982)"—p.87.				
Watkins, D., Edwards, J., & Gastrell, P.	Rumbold, G.	2003	Community health nursing: Frameworks for practice	2nd	10	3.0%	Addresses deontology, utilitarianism, 4 themes (respect for persons, consent, accountability, and advocacy).			Rumbold quotes Seedhouse (1988) stating "the key question for health workers is 'how can I intervene to the highest moral degree?' " Rumbold states "the study of ethics seeks to provide means of formulating answers to questions and so guide actions. It provides a framework for dealing with issues, problems and dilemmas" (p175). Defines and discusses deontology, utilitarianism, respect for persons, respect for autonomy, respect for privacy, and respect for property, consent, accountability, and advocacy.		This chapter lists the key issues (ethical theories, respect for persons, consent, accountability, and advocacy). Information is United Kingdom-based and not Canadian content. Presents case studies throughout the chapter to help apply theory/principle being discussed.

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Allender, J.A., Rector, C., & Warner, K.D.	Rector, C.	2010	Community health nursing: Promoting & protecting the public's health	7th	11	1.2%	Discusses autonomy, beneficence, bioethics, equity, ethical decision-making, ethical dilemma, ethics, fidelity, justice, moral, moral evaluations, nonmaleficence, respect, self-determination, justice, value, value systems, values clarification, veracity, and well-being.	Discusses several decision-making frameworks: three key steps to consider in choosing an alternative course of action: 1. separate questions of fact from questions of value, 2. identify both clients' and nurse's value systems, 3. consider ethical principles and concepts (p.79). Discusses the DECIDE model (p.79). Discusses a model that "helps to organize thoughts and acts as a guide through the decision-making process" (p.80). Another decision-making model that "advocates keeping multiple values in tension before resolution of conflict and action on the part of the nurse" (p. 80). Presents Iserson's (1999) three tests: impartiality test, universalizabilty test, and		"Underlying every issue and influencing every ethical and professional decision are *values*. Ethics and values are inextricably intertwined in professional decision-making, because values are the criteria by which decisions are made" (p. 74). Discusses values, and standards for behavior. Discusses qualities of values (endurance, hierarchical arrangement, prescriptive-proscriptive belief, reference, and preference). Discusses Uustal's seven steps in the process of valuing (p.76) and Uustal's 3 strategies to the decision-making process (pp.76–77): Strategy 1: way for nurses to come to know themselves and their values better; strategy 2: assists in	Rector discusses the basic values in decision-making's (self-determination, well-being, and equity) implications in community health nursing.	This chapter lists the learning objectives and key terms. The chapter discusses two key topics Research and ethics; rather than splitting the two topics up into separate chapters, it combines the information, and specifically addresses ethics over 11 pages (chapter is 25 pages in length). Content is United States-based and not Canadian content. Includes case studies.

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								interpersonal justifiability test (p. 80). Rector discusses the basic values that guide decision-making: self-determination, well-being, and equity.		discovering value clusters and the priority of values within personal value systems; and strategy 3: examine personal responses to selected issues in nursing practice. Defines ethics, ethical decision making, morals, and bioethics. Discusses identifying ethical situations, decision-making frameworks, seven ethical principles (respect, autonomy, beneficence, nonmaleficence, justice, veracity, and fidelity). Discusses ANA code.		
Stewart, M.J.	Stewart, M.J.	2000	Community nursing: Promoting Canadians' health	2nd	0	0.0%						
Stanhope, M., & Lancaster, J.	Silva, M. C, Fletcher, J. J., & Sorrell, J. M.	2005	Foundations of Nursing in the Community: Community-oriented Practice	2nd	15	2.0%	Virtue ethics, caring and the ethic of care, feminist ethics, ethics and the core functions of public, ethical decision making, policy development, nursing	Presents a generic ethical decision-making framework, as well as discusses the rationale of the steps of the framework. Discusses conceptual framework for advocacy and practical framework for				Chapter outlines objectives, presents and defines key terms. Included is "How to" boxes to help apply ethical principles, theory,

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							code of ethics, public health code of ethics. Advocacy (conceptual framework for advocacy and practical framework for advocacy. Communitarianism, consequenialism, deontology, distributive justice, principlism, and utilitarianism.	advocacy.				or philosophy. Ethical cases included to help develop critical thinking skills. At the end of the chapter there's a "Remember this" section to summarize learning." Clinical application" section applies learning, and a "What would you do?" section engages learner on applying learning. Included is an "Additional resources" section for learners to strengthen their learning.

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Stanhope, M. & Lancaster, J.	Silva, M. C, Fletcher, J. J., & Sorrell, J. M.	2010	Foundations of Nursing in the Community: Community-oriented Practice	3rd	15	2.1%	Virtue ethics, caring and the ethic of care, feminist ethics, ethics and the core functions of public, ethical decision making, policy development, nursing code of ethics, public health code of ethics. Advocacy (conceptual framework for advocacy and practical framework for advocacy. Communitarianism, consequenialism, deontology, distributive justice, principlism, and utilitarianism.	Presents a generic ethical decision-making framework, as well as discusses the rationale of the steps of the framework. Discusses conceptual framework for advocacy and practical framework for advocacy.	No major changes.			Chapter outlines objectives, presents and defines key terms. Included is "How to" boxes to help apply ethical principles, theory, or philosophy. Ethical cases included to help develop critical thinking skills. At the end of the ch. there's a "Remember this" section to summarize learning. "Clinical application" section applies learning, and a "What would you do" section engages learner on applying learning. Included is an

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												"Additional resources" section for learners to strengthen their learning.

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Clark, M.J.	Clark, M.J.	1999	Nursing in the Community: Dimensions of Community Health Nursing	3rd	13	1.2%	Defines ethics. Briefly defines principles vs. rules; ethical dilemma; moral reasoning; altruism; virtue ethics; stoicism; ethic of caring; rational paternalism; collectivism; utilitarianism; principles (beneficence, nonmaleficence, justice/equity); individualism, existentialism, libertarianism, rights-based ethics, duty-based ethics (deontology, and contractarianism); egoism; epicureanism; eudemonism).	Presents the dimensions model to address ethical dilemmas. Presents the health dimensions perspective (1. biophysical dimension, 2. psychological dimension, 3. behavioral dimension, 4. health system dimension) to address ethical decision making.		Defines consequentialist, aka situational or teleological ethics (individualism, egoism, utilitarianism, and libertarianism). Defines nonconsequentialist (code of ethics, duty-based ethics, altruism, and virtue ethics). Ethical dilemma examples can be applied to Canadian health care system, however text is reflection on the US health care system; therefore not fully reflective of a Canadian perspective or audience. Text is a reflection of American code of ethics, responsibilities, and law rather than of Canadian code of ethics, responsibilities, and law. Provides examples using the different ethical theories to help illustrate the theories perspective and does not pose one theory greater than another. Briefly discusses evaluation and selecting a course of action in ethical decision-making.		This chapter outlines the objectives, and key terms. Presents a case study to develop understanding. Presents “testing your understanding,” and “what do you think” to engage readers in critical thinking.

Textbook Author(s)/ Editor(s)	Chapter Author(s)	Year	Textbook Title	Edition	# of pages	Overall % of coverage **page numbers noted up until index**	Theory/Theories addressed	Frameworks addressed	Changes/ progression over editions	Discussion of ethics theory/concept	Implications to and ethical challenges within public health	Additional comments/notes
Stanhope, M. & Lancaster, J.	Silva, M. C, Fletcher, J. J., & Sorrell, J. M.	2008	Public Health Nursing: Population-Centered Health care in the Community	7th	16	1.5%	Respect for autonomy, rights-based ethical theory, community-based ethical theory, obligation-based ethical theory, code of ethics, advocacy, justice, health policy, caring, women's moral experiences, and moral character of health practice. Defines Ethics. Discusses values, consequentialism, utilitarianism, and deontology.	Presents a generic ethical decision-making framework. Discusses conceptual framework for advocacy and practical framework for advocacy.		Presents principles, rules, and ideals to guide public health practice; United States content and not Canadian. Discusses the principles (autonomy, non-malfeasance, beneficence, and distributive justice). Discusses Utilitarianism (utility), deontology (categorical imperative), distributive or social justice (egalitarian, libertarian, and liberal democratic), and Communitarianism (virtue ethics, ethic of care, and feminist ethics).		This chapter outlines the objectives, key terms, and chapter outline. Includes "did you know" (interesting facts), "what do you think" (stimulate debate and discussion), "how to" (application-oriented information), "nursing tip" (clinical considerations) = helps broaden learning throughout chapter.

Textbook Author(s)/ Editor(s)	Chapter Author(s)	Year	Textbook Title	Edition	# of pages	Overall % of coverage **page numbers noted up until index**	Theory/Theories addressed	Frameworks addressed	Changes/ progression over editions	Discussion of ethics theory/concept	Implications to and ethical challenges within public health	Additional comments/notes
Stanhope, M. & Lancaster, J.	Silva, M. C, Sorrell, J. M., & Fletcher, J. J.	2012	Public Health Nursing: Population-Centered Health care in the Community	8th	15	1.4%	Advocacy, assurance, principlism, code of ethics, communitarianism, consequentialism, deontology, ethical decision making, feminist ethics, moral distress, policy development, utilitarianism, virtue ethics.	Presents a generic ethical decision-making framework. Discusses conceptual framework for advocacy and practical framework for advocacy.	Removed women's moral experiences, and moral character of health practice.	Presents principles, rules, and ideals to guide public health practice; United States content and not Canadian. Discusses the principles (autonomy, non-malfeasance, beneficence, and distributive justice). Discusses Utilitarianism (utility), deontology (categorical imperative), and Communitarianism (virtue ethics, ethic of care, and feminist ethics).		This chapter outlines the objectives, key terms, and chapter outline. Includes "did you know" (interesting facts), "what do you think?" (stimulate debate and discussion), "how to" (application-oriented information), "nursing tip" (clinical considerations) = helps broaden learning throughout chapter.

Appendix C: Theories and Principles

Textbook Author(s)/Editor(s)	Year	Ed.	Principles (4 or 7)	Pluralism	Relativism	Rule ethics	Virtue ethics	Feminist Ethics	Advocacy	Universalism	Teleology	Deontology	Ethics vs. Law	Genetic Engineering	Cultures	Health Promotion	Globalisation	Ethic of Care	Utilitarian	Rights based	Contractarianism	Community based	Consequence based	Obligation based	Health Policy	Equality or Equity	Caring	Women's Moral Experiences	Moral Character	10 Moral Rules	Codes of Ethics	Other
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2004	1st	4																✓											✓		4 Societal Factors
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2008	2nd	7	✓	✓	✓	✓	✓	✓							✓																ANA code of ethics	7 foundational ethical concepts (inclusion, diversity, participation, empowerment, social justice, advocacy, and interdependence).
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2012	3rd	7	✓	✓	✓	✓	✓	✓							✓																ANA code of ethics	7 foundational ethical concepts (inclusion, diversity, participation, empowerment, social justice, advocacy, and interdependence).
Anderson, E.T., & McFarlane, J.M.	1996	2nd	0						✓	✓																							Paternalism vs. Consumerism
Anderson, E.T., & McFarlane, J.M.	2000	3rd	0						✓	✓																							Paternalism vs. Consumerism
Anderson, E.T., & McFarlane, J.M.	2008	5th	7						✓		✓	✓	✓								✓												Paternalism vs. Consumerism
McMurray, A.	1999	1st	4											✓	✓	✓																	
McMurray, A.	2007	3rd	0														✓																
Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2008	1st	4				✓	✓				✓					✓		✓	✓		✓	✓	✓	✓		✓	✓	✓			CNA code of ethics	Determinants of health is referred to and readers are re-directed to a previous chapter. Egalitarianism, Libertarianism, and liberal democratic.
Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2011	2nd	4				✓	✓	✓			✓						✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			CNA code of ethics	Upshur's (2002) principles - harm principles, principle of least restrictive means, reciprocity principle, and transparency principle). Determinants of health is referred to and readers are re-directed to a previous chapter. Egalitarianism, Libertarianism, and liberal democratic.
Diem, E. & Moyer, A.	2005	-----																															
Stamler, L.L. & Yiu, L.	2005	1st	0					✓	✓							✓		✓														CNA code of ethics	Canadian Nursing central values (safe competent ethical care, health and wellbeing, choice, dignity, confidentiality, justice), accountability, and quality practice environment. Community health nurses standards of practice.
Stamler, L.L. & Yiu, L.	2008	2nd	0					✓	✓							✓		✓														CNA code of ethics	Canadian Nursing central values (safe competent ethical care, health and wellbeing, choice, dignity, confidentiality, justice), accountability, and quality practice environment. Community health nurses standards of practice. Upshur's (2002) principles - harm principles, principle of least restrictive means, reciprocity principle, and transparency principle). Canadian Nursing central values (safe competent ethical care, health and wellbeing, choice, dignity, confidentiality, justice), accountability, and quality practice environment. Community health nurses standards of practice.
Stamler, L.L. & Yiu, L.	2012	3rd	0						✓							✓		✓														CNA code of ethics	Canadian Nursing central values (safe competent ethical care, health and wellbeing, choice, dignity, confidentiality, justice), accountability, and quality practice environment. Community health nurses standards of practice. Upshur's (2002) principles - harm principles, principle of least restrictive means, reciprocity principle, and transparency principle). Canadian Nursing central values (safe competent ethical care, health and wellbeing, choice, dignity, confidentiality, justice), accountability, and quality practice environment. Community health nurses standards of practice.
Clark, M.J.	2008	5th	0																														
Clark, M.J.	2003	4th	0																														
Lundy, K. S. & Janes, S.	2009	2nd	4				✓					✓						✓	✓			✓	✓		✓							ANA code of ethics	Beauchamp and Childress (1994) 4 virtues - compassion, discernment, trustworthiness, and integrity.
Hitchcock, J.E., Schubert, P.E., & Thomas, S.A.	2003	2nd	7					✓				✓							✓								✓					ANA code of ethics	
Allender, J.A. & Spradley, B.W.	2001	5th	7																							✓					ANA code of ethics	Values and Morals is discussed. Instrumental and terminal values. Moral evaluations. Self-determination. Self-interest. Value systems, and value clarification.
Watkins, D., Edwards, J., & Gastrell, P.	2003	2nd	0						✓			✓							✓													UK codes of ethics	4 themes (respect for persons, consent, accountability, and advocacy).
Allender, J.A., Rector, C., & Warner, K.D.	2010	7th	7																							✓					ANA code of ethics	Bioethics. Morals, and Moral evaluations. Standards of behavior.
Stewart, M.J.	2000	2nd	0																														
Stanhope, M. & Lancaster, J.	2005	2nd	4				✓	✓	✓	✓		✓						✓	✓			✓	✓		✓		✓					ANA code of ethics	Public health code of ethics
Stanhope, M. & Lancaster, J.	2010	3rd	4				✓	✓	✓	✓		✓						✓	✓			✓	✓		✓		✓					ANA code of ethics	Public health code of ethics
Clark, M.J.	1999	3rd	4			✓	✓					✓						✓	✓	✓	✓		✓						✓	✓			Moral reasoning. Atruism. Stoicism. Rational paternalism. Collectivism. Individualism. Existentialism. Libertarianism. Egoism. Epicureanism. Eudaimonism.
Stanhope, M. & Lancaster, J.	2008	7th	4					✓	✓			✓							✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		ANA code of ethics	
Stanhope, M. & Lancaster, J.	2012	8th	4					✓	✓			✓						✓	✓			✓	✓	✓	✓		✓					ANA code of ethics	Public health code of ethics

Appendix D: Ethical Decision-making Framework

Textbook Author(s)/Editor(s)	Year	Edition	*Health Canada's 5 Levels of public involvements continuum*	*Checklist for public participation planning process*	*Advocacy model*	*Human needs*	*Generic model*	*Kass' (2001) 6 step framework*	*"Problem-solving format"*	*6 component framework (determining involvement, gathering data, outlining options and consequences, process for resolving conflict, planning for action/implementation, and evaluation*	*Utstal's 7 step process of valuing*	*Utstal's 3 strategies*	*Thompson & Thompson's (1992) decision-making framework*	*DECIDE model*	*Iserson's (1999) three tests: impartiality, universalizability, and interpersonal justifiability test*	*Dimensions model*	*Values Clarification*
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2004	1st	✔	✔													
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2008	2nd															
Vollman, A. R., Anderson, E.T., & McFarlane, J.	2012	3rd															
Anderson, E.T., & McFarlane, J.M.	1996	2nd															
Anderson, E.T., & McFarlane, J.M.	2000	3rd															
Anderson, E.T., & McFarlane, J.M.	2008	5th				✔											
McMurray, A.	1999	1st															
McMurray, A.	2007	3rd															
Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2008	1st			✔		✔										
Stanhope, M., Lancaster, J., Jessup-Falcioni, H., & Viverais-Dresler, G.A.	2011	2nd			✔		✔										
Diem, E. & Moyer, A.	2005	------															
Stamler, L.L. & Yiu, L.	2005	1st															
Stamler, L.L. & Yiu, L.	2008	2nd															
Stamler, L.L. & Yiu, L.	2012	3rd															
Clark, M.J.	2008	5th															
Clark, M.J.	2003	4th															
Lundy, K. S. & Janes, S.	2009	2nd						✔	✔								
Hitchcock, J.E., Schubert, P.E., & Thomas, S.A.	2003	2nd					✔			✔							
Allender, J.A. & Spradley, B.W.	2001	5th									✔		✔				✔
Watkins, D., Edwards, J., & Gastrell, P.	2003	2nd															
Allender, J.A., Rector, C., & Warner, K.D.	2010	7th					✔				✔	✔		✔	✔		✔
Stewart, M.J.	2000	2nd															
Stanhope, M. & Lancaster, J.	2005	2nd			✔		✔										
Stanhope, M. & Lancaster, J.	2010	3rd			✔		✔										
Clark, M.J.	1999	3rd														✔	
Stanhope, M. & Lancaster, J.	2008	7th			✔		✔										
Stanhope, M. & Lancaster, J.	2012	8th			✔		✔										

Appendix E: Ethical Decision-making Framework Definitions

Advocacy model, practical and conceptual See pages 24–26 above for discussion.

Generic model Silva, Sorrell, Fletcher (2012) listed seven steps in a generic ethical decision-making framework: "Identify the ethical issues and dilemmas; place them within a meaningful context; obtain all relevant facts; reformulate ethical issues and dilemmas, if needed; consider appropriate *approaches* to actions or options (utilitarianism, deontology, principlism, virtue ethics, ethic of care, feminist ethics); make the decision and take action; and evaluate the decision and the action" (p. 128).

Generic ethical decision-making model, as introduced by Case (2003) Case's generic ethical decision-making model included a five-step process: Assessment, analysis and diagnosis, planning, implementation, and evaluation.

Problem-solving format Kurtz and Burr (2009) stated that decision-making models' foundations arise from a problem-solving format of five steps: Determining the affect on autonomy and quality of life; separate ethical issues from medical issues and determine who will be affected; identify and understand the values of those involved; develop alternative options; and decide on a course of action and evaluate the outcome.

Health Canada's five levels of public involvement continuum Vollman et al. (2004) drew attention to Health Canada`s five levels of public involvement, with a note on how to engage the public into participation. The public participation planning process includes a planning checklist consisting of the following six components: Preparation, design, implementation, synthesis, feedback and follow-up, and evaluation. The following are the five levels of public involvement:

- Level 1: Inform or Educate—communication
- Level 2: Gather information—listening
- Level 3: Discuss—consulting
- Level 4: Engage—engaging
- Level 5: Partner—partnering

Values clarification Rector (2010) stated that the value clarification process enables personal and professional values to be examined.

Uustal's seven-step process of valuing and values clarification Rector (2010) listed Uustal's seven steps to help clarify values for individuals: Choose the value freely and individually; choose the value from among alternatives; carefully consider the consequences of the choice; publically affirm the chosen value; incorporate the value into behavior, so that it becomes a standard or a pattern of behavior; and consciously use the value in decision making (p. 76).

Human needs framework Walker (2008) stated that this framework helps evaluate a choice of action within a community-as-partner model. The framework progresses and encourages courses of action to consider needs to be addressed in the following order: Physiological, safety, belonging, self-esteem, and self-fulfillment.

Kass' (2001) six-step framework Kurtz and Burr (2009) introduced Kass' framework, which poses six questions for program developers within the public health profession to question:

- "What are the public health goals of the proposed program?
- How effective is the program in achieving its stated goals?
- What are the known or potential burdens of the program?
- Can burdens be minimized?
- Is the program implemented fairly?
- How can the benefits and burdens of a program be fairly balanced?" (p. 264).

Six-component framework, as described by Case (2003). Case's (2003) six-component framework stated that the following components needed to be addressed: Determining involvement; gathering data; outlining options and consequences; process for resolving conflict; planning for action/implementation; and evaluation.

Uustal's three strategies Rector (2010) introduced Uustal's (1978) strategies useful in the decision-making process. Uustal's three strategies were:

- Strategy 1: "way for nurses to come to know themselves and their values better" (p. 77).
- Strategy 2: "discovering value clusters and the priority of values within personal value systems" (p. 77).
- Strategy 3: "examine personal responses to selected issues in nursing practice" (p. 77).

Thompson and Thompson's (1992) decision-making framework Spradley and Allender (2001) introduced a framework by Thompson and Thompson which "includes the identification and clarification of values impinging on the making of ethical decisions." The following are steps of Thompson and Thompson's decision-making framework:

- Review the situation (What health problems exist? What decisions need to be made? Separate ethical components of the decision from those decisions that can be made solely on a scientific knowledge base; identify all individuals or groups affected by the decision).
- Decide what further information is needed before a decision can be made.
- Identify ethical issues. Discuss historical, philosophical, and religious bases for these issues.
- Identify your own values and beliefs. Identify professional responsibilities dictated by the ANA's *Code for Nurses with Interpretive Statements.*
- Identify values and beliefs of other people involved in the situation.
- Identify any value conflicts.
- Decide who should make the decision. Determine the nurse's role in making the decision.

- Identify the range of possible decisions or actions. Determine implications for all people involved. Identify how suggested actions conform to the ANA's code for nurses.
- Decide on a course of action and follow-through.
- Evaluate the results of the actions or decisions and what has been learned for use in reviewing and resolving similar further situations" (pp. 85–86).

DECIDE model The DECIDE model is "a practical method of making prudent value judgements and ethical decisions" (Rector, 2010, p. 79).

- D – Define the problem (or problems)
- E – Ethical review
- C – Consider the options
- I – Investigate outcomes
- D – Decide on action
- E – Evaluate results

Iserson's (1999) 3 tests Iserson's three tests are as follows:

- Impartiality test: "the golden rule"
- Universalizablity test: "universal rule"
- Interpersonal justifiability test: good reason

Dimensions model Clark (1999) introduced the dimensions model as an approach from both an individual and community perspective. From an individual perspective, nurses act as advocates; from a community perspective, nurses focus on health policies as an intervention. The Dimensions model comprises five dimensions: biophysical, psychological, social, behavioral, and health system.