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About the cover: Judy Runnels, former staff nurse at the University of Kansas Medical Center, now serves as legislative liaison to Governor John Carlin. Prior to this appointment, Judy worked as a KSNA lobbyist.
Y ou have been working in a large, county-operated metropolitan hospital for just under a year since earning your cap and your first promotion, which is a sort of in-hospital nursing home or have repeatedly been referred to a ward on which you have been working in a large, county-operated metropolitan hospital for just under a year since earning your cap and your first promotion, which is a sort of in-hospital nursing home.

As you begin to familiarize yourself with the charts that the question of resuscitation has been discussed with family members, particularly since the hospital is in an area of the Sun Belt where elderly people move to retire away from their children. You are greatly disturbed by this; but inquiry from a nurse can provoke, particularly when coming from one who doesn’t have a solid power base, you determine to be on firm footing before protesting the ethics of the practice. You decide to review your copy of the ANA Code of Ethics for Nurses (a document which you received when you joined the ANA but which you have scarcely glanced at so far), so that you can point out that the profession backs you up in your opposition to the practice. Alas! When you read the 11 points of the Code, although it contains some strong general statements about your duty to safeguard your client from unethical practice, the Code doesn’t say whether the practice of No Coding is unethical or not. You expand your reading to the accompanying set of Interpretative Statements and read them very carefully, but again you do not find the specific condemnations that you seek. Where age and long-term illness are mentioned, the nurse is enjoined not to let those factors limit practice except insofar as is appropriate to the circumstances of the individual case.

"The Code for Nurses cannot answer all moral questions..." the circumstances of the individual case. About the only explicit point that speaks to your type of situation occurs where the Code allows that the nurse who is personally opposed to the procedures used in a particular case is justified in refusing to participate. But this seems to land you in the same old quandary: you either swallow your dislike for what is being done and remain at your new post, or ask to be transferred to another ward on personal grounds and risk being labeled a malcontent early in your still vulnerable career. You seem unable to find professional backing in the Code for your opposition to the practice and wonder if maybe it is just a matter of your personal values rather than an ethically questionable practice at stake. You finally decide that you can’t fight city hall, particularly if you are banished from the city and so you learn to live with the situation, occasionally “overlooking” the No Code orders and spending a lot of sleepless nights hoping for another transfer (which eventually comes).

I believe that the nurse in this hypothetical but all-too-common scenario is the victim of one of several mistaken views as to just what a professional code of ethics does and can do. The topic of this essay is an examination of those several views, but at bottom lies the question “Would nurses and/or others in the health care and medical professions be better off with codes, or no codes?” A document published by the Committee on Ethics of the ANA in 1979 contains three sentences all the more remarkable for their juxtaposition. “The statements of the Code and their interpretation provide guidance for conduct and relationships in carrying out nursing responsibilities consistent with the ethical obligations of the profession and quality in nursing care.” “The Code for Nurses cannot answer all moral questions and tell the nurse what she ought to do in each particular situation. Codes can deal only with broad issues and suggest general ethical stances.” What is remarkable about the juxtaposition is that the first sentence appears to offer a promise that is removed by the other two. The initial premise is that the Code serves as a guide to “conduct and relationships in carrying out nursing responsibilities” that are ethical and professional, yet the pair of sentences that immediately follow make a rather weaker claim on behalf of the Code. They indicate that it should be read not as providing specific, situational directives but as only “suggestive” of ethical stances.

The foregoing comments make it surprising to find yet another view of codes in the literature. May observes that a code of medicine, in the form of nonreferral to one discipline and he observes that ostracism in medicine, in the form of nonreferral to one discipline, "is probably the commonest and most effective form of discipline in (that) profession today.” And Davis and Aroskar note that “The requirements of the (ANA) Code may often exceed, but are not less than, those of the law. While violation of the law subjects the nurse to criminal or civil liability, the Association may reprimand, censure, suspend, or expel members from the Association for violation of the code.” (Italics added.)

There are thus at least three views of the Code extant in the literature: (i) the Code is intended to provide individual nurses with ethical guidance in their conduct; (ii) the Code is intended as suggesting general stances which nurses might wish to consider seriously on broad issues.

Ethics
confronted by the profession; (iii) the Code expresses profession-wide standards that are to serve as the basis for peer discipline and quality assurance within the profession. In my role as a non-nurse observer and commentator on the profession, I want to consider each of these views and indicate what I take the arguments to be in support and in opposition of them. As one might suspect, it seems to me that each is partly right and partly wrong. I then want to offer a fourth view of the Code and the role that it can and should play. Finally, I will return to our hypothetical situation of the nurse confronted with an ethical knot and indicate how the Code might be best used to unravel it.

Earlier in this series, I criticized the view that codes provide a kind of ethical catalogue or recipe for the conduct of the professional and I am not alone in that rejection. First of all, simply by laying side by side the codes of different professions, one can easily observe that those codes commend different and sometimes conflicting courses of actions to members of different professions involved in a common case. Consider the question of confidentiality. The American Hospital Association’s Patient’s Bill of Rights, readily available to any patient hospitalized in an ANA-member institution, asserts that “the patient has the right to privacy concerning his own medical care program (and) to confidential communication and records.” A patient reading that (in 1979) might well have concluded that the facts about his case would be made known only to parties having a direct role in his treatment or care (or the accompanying record-keeping). Should the jumble of pamphlets on the lamp table of his lounge area have also contained a copy of the International Code of Medical Ethics (1949), this expectation would have been strongly reinforced. “A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.” A small worry might have been raised in our patient if he had perused the ANA Code for Nurses (1976), reading that “the nurse safeguards the client’s right to privacy by judiciously protecting information of a confidential nature” (emphasis added) since it appears to leave the matter of disclosure somewhat up to the nurse’s judgement. But he would have been reassured by the repeated emphasis in the interpretative statements on the nurse’s responsibility to obtain consent for disclosure and to safeguard the information from others not involved in the patient’s care. But, should our patient have then relaxed in the belief that his interests were unequivocally protected by every professional code involved, he might have been in for a rude shock.

For the American Medical Association’s 1957 Code qualified the physician’s obligation not to breach confidence, not only when required to do so by law, but also when “it becomes necessary in order to protect the welfare of the individual or of the community.” What seemed clear grows murky; for just what comprised the welfare of the community (and indeed perhaps what counted as the community as well) was left up to the individual physician in cases where the law had not spoken. Better read all the codes, John Q. Patient!

Nor do the problems with codes’ ability to guide involved parties towards ethical conduct stem only from inter-code disparities; a given code may provide conflicting directives. The 1965 International Code of Nursing Ethics held that the nurse had a three-fold responsibility: “to conserve life, to alleviate suffering and to promote health.” Hunt and Arras suggest that a nurse who must counsel the parents of a severely deformed newborn child may not be able to meet all of these responsibilities. (Perhaps an awareness of the growing power of medicine to prolong the lives of such unfortunates without curing them prompted the revision of the International Code in 1973 to strike the clause concerning conservation of life and to add clauses enjoining prevention of illness and restora-
tion of health.)12 I have elsewhere13 mentioned the conflict that may result from pursuing as a researcher the development of nursing’s body of knowledge when the nature of a particular research problem dictates the use of either placebo or other forms of deception, or of standard double-blind techniques in which the subject is either ignorant of what is actually being done to him or is allowed to make a predictably wrong assumption. And one may well imagine conflicts between the nurse’s obligation to provide services “unrestricted by considerations of . . . economic status” and the obligation to “participate in the profession’s efforts to establish and maintain conditions of employment conducive to high quality nursing care”,14 which neither in itself nor in the Interpretative Statements explicitly excludes work slowdowns, stoppages and strikes under extreme conditions.

These problems of internal consistency of codes stem in part from a lack of explicit ordering principles — that is, instructions as to which principle to preserve in the face of a conflict — and in part from the inherent difficulty of formulating a set of rules both manageably finite and sufficiently encompassing to cover every tortuous situation one may encounter. To be fair, it should be noted that some effort has gone toward providing that type of guidance in the ANA Interpretative Statements, as when a limit is imposed on a nurse’s individual agreements with potential employers to providing practices and services which do not violate the Code. However, nothing even approaching a complete set of ordering principles is included in the Code.

Perhaps we can agree that the Code cannot stand alone as providing individual nurses with the guidance needed to ensure ethical conduct in their professional lives, in that it does not consistently apply to all nursing situations and it fails to square with all the requirements of other professional codes with the same putative status as directives. Finally, there is the important point that a nurse may have other ethical commitments which conflict with those prescribed by the code. While “each client has the moral right to determine what will be done with his/her person”,15 “if a client requests information or counsel in an area that is . . . contrary to the nurse’s personal beliefs, the nurse may refuse to provide these services but must advise the client of sources where such service is available.”16 This may leave a client high and dry in seeking a particular kind of legal service where the nurse who declines on the basis of a personal belief is that client’s only realistic source of that service — thereby rendering that right of self-determination hollow. Nurses faced with this sort of dilemma find themselves torn between their rights as persons and their roles as representatives of the profession.

On the other hand, the view that the Code serves, rather than as a specific ethical guide, as a source of “suggestions of general stances” to be considered seriously (a sort of nurses’ “Dutch uncle”) seems rather insipid, inviting the amused inattention a Dutch uncle usually gets. Certainly the issues covered in the Code are

“There is no harm in the Code functioning to keep one morally mindful . . .”

ones which any nurse should consider and the stands endorsed there are worthy of serious attention. But the language of the Code is far stronger, indicating what the nurse does and must do in language that demands heeding, not merely consideration. The points at which the individual wishes or preferences of the nurse are properly to be exercised are specified explicitly and they would be so indicated rather misleadingly if the rest were also merely suggestive and ultimately up to the individual nurse. This is especially so if, as the third point holds, the Code serves as a basis for peer discipline. However, since we have argued that the Code is not sufficient as a basis for moral behavior in every nursing situation, perhaps there is something to a view which says that one of the Code’s proper functions is to suggest areas of particular concern and directions of a general sort as to the basic boundaries within which the spectrum of one’s decisions should fit to count as moral. There is no harm in the Code functioning to keep one morally mindful, if one also bears in mind that the Code may also be the basis for barring those who deviate from its prescriptions from future gainful employment as nurses.

This third view of the Code, that it serves as an instrument of peer regulation, fits in with the usual philosophical understanding of nursing as a profession. Jaggar17 observes that a code of professional ethics, “like the test of professional competence, is designed by the profession itself and enforced by the use of in-group sanctions” and she counts a code as one of the defining characteristics of a profession (as a chief means for controlling continuing competence and fitness to practice). I find it interesting that codes in general are determined by those offering a particular type of service for compensation, rather than by those who pay for that service (or their representatives). Although no statement avows it explicitly, the practice of self-regulation through promulgation and enforcement of codes of ethics by members of the profession smells to the consumer of the familiar odor of paternalism. It is a matter of some concern to the code of a new Code of ethics for the AMA being drawn up by a panel of MD’s without a single non-AMA member on it and passed at the annual convention was defended by the panel’s chair, James Todd, on the grounds that nonphysicians (and presumably non-AMA physicians as well) “don’t understand all the ramifications.”18 (It’s also interesting to note that the AMA physicians themselves may not have been fully understanding “all the ramifications” until now, for the new code incorporates substantial changes in acknowledging patient’s rights, permitting advertising, and allows physician referrals to chiropractors — practices that were restricted and rights that were limited in the 1957 AMA Code.)

Thus, the practice of generating codes as self-regulating devices can be seen not only as conservative devices which uphold current standards embodying the best in a tradition’s history, but also as devices for insulating a profession against unwanted incursions from outside the ranks of its own. Despite Todd’s defense, it is no surprise that the recent spectacle of the AMA’s Code, which reflects both the patients’ rights movement, the approximate annual $1 million costs of lawsuits brought by chiropractors charging physicians with failure to provide them with referrals, and the 1979 Federal Trade Commission’s ruling that the AMA’s traditional ban on advertising was not in the consumer’s interests because it restricted competition between physicians. Despite Todd’s defense, this really doesn’t look like a case of “Physician, heal thyself!”

In speculating on the causes of the rather dramatic recent changes in the AMA code and of similar changes throughout the history of various professional organizations, yet a fourth interpretation of the functions of the practice of issuing codes (particularly in a multi-profession field such as medical and health care) occurs to me. Codes function much the same way as do platforms of political parties and candidates. Both codes and platforms serve to give the sense of common commitment in matters of principle which bind together members of the same group (profession or party) at a given point in time; they also record changes in those commitments as generations of the profession or party react to changes in other aspects of the culture with which they are involved. Viewed in this way, codes and platforms serve both as brakes on too rapid change and as records of fundamental reorientations of their groups in response to both
changing powers and new demands which technology and its socialization thrust upon them.

Codes thus are to be seen, in addition to moral guides and reminders and devices for peer control, as cultural instruments of communication about what is commonly expected of the professional by peers, other professionals and consumers of their services alike. Insofar as such communication is essential to the very identity and integrity of a profession, codes are absolutely indispensable.

This communicative function is particularly well served by the ANA Code for Nurses together with its Interpretative Statements. One editor commends the Code for identifying the underlying values and beliefs, showing the breadth of the profession’s social concerns, and identifying a commitment to accountability not only to professional peers but also to clients. In these respects the ANA Code is noteworthy for its “distinctiveness among codes of ethics,” particularly since it lacks much of the philanthropic condescension to be found in many medical codes, as noted by May.

Thus, our hypothetical nurse has incompletely understood the functions of the Code of her or his profession. It should have been taken as a statement of the convenant which exists among nurses to protect and nourish the gift of knowledge and skill imparted by their teachers. That convenant includes commitments not only to peer review of competence and its continued maintenance and to the correlative development and implementation in practice of the body of knowledge on which that practice rests; it also recognizes a commitment to organization and implementation of official mechanisms within institutions, agencies and the society at large that encourage the raising of concerns, such as troubled our nurse, without fear of reprisal. One does not protest effectively or very long armed only with a list of don’ts; one does see protest effect change when backed by the power of a professional organization. The Code thus serves as a convenant between the nurse and his/her profession, a promise of what the nurse may expect of the profession if she/he conforms to what the profession expects of the nurse.

Nursing has a fine document in the ANA Code with Interpretative Statements, a document which articulates a mature image of the professional nurse appropriate for our time. Let me suggest that the profession give attention to the question of how to make alive in the nurse’s daily practice the sense of convenant which is embodied in its Code. That would be a step closer toward recapturing that image it projects for each nurse. Had that held for our hypothetical nurse, she would not still be left wondering, “Code, or no code?”

Footnotes
2 American Nurses’ Association, Ethics in Nursing: References and Resources, Kansas City, MO: ANA 1979 (p 1).
7 ANA Code, op. cit., Point 2.
9 The recently passed 1980 ANA Code is reported to have eliminated the clause ensuring protection of the community apart from legal restraints. See below, in 2.
11 Ibid.
14 ANA Code, op. cit., Points 1 and 9.
15 Ibid., Point 1.
16 Ibid., Point 1.4 in the Interpretative Statements.