Chapter 14
Ethical Leadership and the Context for Ethical Practice in Health Care Organizations

Learning Objectives
After reading, studying, and reflecting on this chapter's content, you will be able to:
1. Discuss the concepts of moral agency, moral distress, and moral climate
2. Discuss the concept of character and the characteristics of ethical leadership
3. Describe qualities of a workplace that would promote a positive ethical climate
4. Discuss ways in which nursing leaders can promote ethical practice in the workplace
5. Identify resources for ethics in the workplace and discuss their use in supporting ethical practice
INTRODUCTION

In your nursing classroom and clinical courses, you learn about the ethical aspects of nursing practice and focus on the kinds of issues that may arise in different clinical settings. For example, consent to treatment may be an issue in areas where nurses work with individuals whose cognitive capacity is in question, such as pediatrics, neurology, psychiatry, and geriatrics. Your nursing courses introduce you to knowledge, tools, and skills that you use to address ethical concerns. For example, you learn about nursing codes of ethics and ethical principles such as autonomy and beneficence that are considerations in analyzing moral situations. (Please note that we use the terms “ethical” and “moral” interchangeably in this chapter.) The focus of these courses is usually on the ethical responsibilities of the individual nurse in relation to patients and their families, obligations to individuals, and the duty of care. The focus on decisions at the individual level is a micro-level one, while a focus on health policy at the government level would involve macro-level decisions (Rodney, et al., 2013). In this chapter we focus on the middle or meso-level, where decisions are made within the context of health care organizations. We do not address specific ethical or legal issues related to clinical situations, but rather how nurses experience these issues in daily practice, how organizations can be structured to address the ethical aspects of health care, and the ethical aspects of leadership roles in nursing.

We begin the chapter with a focus on the ethical aspects of practice in the workplace and discuss what is known about the experiences of nurses in this regard. We discuss key concepts in ethical practice, such as the moral climate and moral culture of a workplace. As all nurses have opportunities and experiences in leadership, we discuss the concepts of ethical leadership and ethical leaders. In particular, we discuss ethical leadership in nursing and how formal leaders can facilitate ethical practice in the workplace. We discuss standards for health care organizations with respect to ethics, issues in organizational ethics, and resources for nurses in the workplace.

ETHICS IN THE NURSING WORKPLACE

The expectations for ethical practice in nursing are identified in nursing codes of ethics or ethical guidelines, be they international (International Council of Nurses, 2012), national (American Nurses Association, 2009; Canadian Nurses Association, 2008), or jurisdictional. For example, in Canada, some provincial nursing regulatory bodies have a code or guidelines on ethics for nurses who are registered or licensed to practise in that province (College of Nurses of Ontario, 2009; L’Ordre des infirmières et infirmiers du Québec, 2012). Although these codes and guidelines set the norms or standards for ethical behaviour, to what extent do nurses believe they meet these standards in their daily practice? Although there has been evidence from many countries that nurses may experience moral distress because of workplace constraints on their practice, concerns about this problem were heightened in Canada during the healthcare cutbacks of the 1990s (Baumann et al., 2001; Cummings & Estabrooks, 2003). The cutbacks led to loss of nursing positions and increased workloads while decreasing supports in the workplace. As a result, a number of studies have been done over the past 15 years and we have learned more about the experiences of nurses, their perceptions of ethical issues in their work settings, and contextual
factors that affect their ability to practise in accordance with their ethical beliefs (Gaudine, et al. 2011a; Storch, et al., 2002). Several key concepts have emerged from theory and research about ethical nursing practice, and these ideas are discussed next.

**Moral Agency**

**Moral agency** refers to “the capacity or power of a nurse to direct his or her motives and actions to some ethical end” (CNA, 2008, p. 26). In essence, the moral agency of a nurse refers to doing what is right through choice and deliberate action. As Rodney, Buckley, Street, Serrano, and Martin (2013) note, one difficulty with the traditional notion of moral agency is that it assumes all those involved in a situation are independent and in a similar situation. They point out that, in the health care environment, there are often power imbalances that constrain nurses from acting as moral agents. In some settings, nurses become socialized into thinking and feeling constrained to the point that they do not act as autonomous moral agents. Such situations are serious and must be corrected through nursing leadership in action.

**Moral Distress**

Andrew Jameton (1984) is a philosopher who explored the ethical dilemmas of nurses in their practice, and he defined **moral distress** as occurring “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Wilkinson (1987/88) developed a moral distress model based on her study of 24 nurses and described the “psychological disequilibrium and negative feelings state” (p. 16) of nurses who did not act in accordance with their moral decisions due to external or internal constraints. External constraints were most often physicians, law, nursing administration, and hospital administration/policy. Internal constraints referred to such things as fear of job loss, self-doubt, a sense of futility based on previous experience, and internalized socialization of nurses to carry out orders. Corley (2002) proposed a theory of moral distress that addressed the internal psychological effects on nurses and nurses’ external context, that is, institutional constraints. The psychological effects on nurses range from anger and frustration to sadness, anxiety, and guilt. Webster and Baylis (2000) describe **moral residue** as a lingering sense of having compromised one’s own values. Nurses may carry this sense of guilt and of having betrayed themselves long after an experience of moral distress.

Most of the research on moral distress among nurses has focused on nurses in acute care hospitals, although there have been some studies in long-term care (Green & Jeffers, 2006) or some that included nurses from such settings (Austin, Bergum, & Goldberg, 2003). In a meta-synthesis of studies of the experience of moral distress of nurses in hospital settings, Rittenmeyer and Huffman (2009) included 39 studies that met the review criteria. Their key findings or syntheses are presented in Box 14.1.

Similar experiences of moral distress seem to occur among nurses no matter what the work setting. In their hermeneutic phenomenological study of Canadian nurses in mental health-care settings, Austin, Bergum, and Goldberg (2003) describe the anguish of nurses in long-term care and acute care settings who feel overworked and too busy to sit with a
A patient who is dying or address someone who is screaming due to “mental pain.” One nurse describes the frustration of seeing colleagues “give up” and feeling alone and “disconnected” (p. 181).

**Moral Climate**

**Ethical** or **moral climate** refers to the current values (both explicit and implicit) that influence a workplace and the professional practice within that workplace (CNA, 2008; Rodney, Buckley et al., 2013). For example, a work setting that values the dignity and privacy of patients has a structural configuration, equipment, supplies, and policies that enable staff to work in a way that promotes these values. There are locations in the setting for private discussion with patients and families about personal issues, patient gowns and curtains are in working order, and staff members do not discuss patients in public areas. Values in the broad health care system can also influence moral climate, for example, when an emphasis on cost savings or business efficiency prevails and leads to decisions that fail to take patient safety into consideration. Moral culture is a similar concept, but refers to the part of an organization’s culture that can influence moral reasoning and decision making within the organization. The formal and informal systems in an organization that influence moral decision making include peer and leadership behaviour, ethical norms, codes of conduct/practice, and reward systems (Brown & Treviño, 2006). For example, in the culture of a hospital, nurses may receive positive comments and congratulations for ensuring patients are discharged by 10:00 hours without regard to the quality of discharge planning and readiness of patients to return home.
Moral distress among nurses has been shown to be associated with the ethical climate of a workplace. Pauly, Varcoe, Storch, and Newton (2009) studied registered nurses working in acute care hospitals in British Columbia using a survey method that involved the measurement of moral distress intensity and frequency as well as hospital ethical climate. A random sample of 1,700 nurses yielded a total of 374 returned surveys (22 percent). Moral distress intensity scores could range between 0 and 6, and moral distress frequency between none (0) and very frequently (6). The items with the highest moral distress intensity scores (greater than 4) were:

- working with perceived unsafe RN staffing,
- being required to work with patients when the nurse did not feel competent to do so,
- working with RNs who were perceived to not be as competent as the patients required,
- working with doctors who were perceived to not be as competent as the patients required, and
- assisting a physician who was viewed as providing incompetent care.

Although moral distress was not a frequent occurrence among respondents, it tended to be intense when it did occur.

Pauly and colleagues (2009) measured hospital ethics climate with a scale that ranged from 1 (almost never true) to 5 (almost always true) and that addressed five factors: peers, patients, managers, hospital, and physicians. A high total score indicated a positive ethical climate. The researchers found a significant, negative correlation between the hospital’s ethical climate and nurses’ levels of moral distress—higher levels of hospital’s ethical climate were associated with lower levels of nurses’ moral distress. All the five factors in the hospital ethics climate scale correlated with nurses’ moral distress, indicating that there are different contributing factors for a hospital’s ethical climate. While many authors have focused on institutional constraints as a source of moral distress, Pauly et al.’s research findings highlight five sources. They conclude that further study and consideration of the relationship of moral distress and ethical climate is needed so that improvements in care can result from consideration of multiple strategies. For example, improvements in relationships with peers, managers, physicians, and others might enhance the ethical climate in a workplace. As Storch (2010) notes: “Although nurses share responsibility for working together to enhance the quality of their work environment, they cannot do so alone. Health agencies are complex organizations that involve many players and many policies that may at times be at odds with good nursing practice and nursing ethics” (p. 20).

**Moral Community**

**Moral community**, in the context of a workplace, involves clear and shared values that guide practice and fosters a safe climate for all participants to be heard (CNA, 2008). Discussion of ethical issues, problems, and values is encouraged and supported. Rodney, Buckley et al., (2013) refer to the period of the 1990s in Canada as having had a profound impact on the moral climate for nursing practice. Reductions in staff and nursing leaders
within health care organizations along with rapid changes with little or no input from nurses led to burnout and job dissatisfaction. Rodney, Buckley et al. believe that workplaces where nurses have been devalued, disenfranchised, and demoralized must be rebuilt and values-based change is required if good nursing care is to prevail: “A minimal requirement for improving the moral climate for nursing practice and fostering the development of nursing as a moral community is to turn the negative characteristics around and strengthen the positive characteristics” (p. 198).

They indicate that a beginning would involve assisting nurses to find their moral voices, to help them use the language of ethics, and to engage in ethics education for nurses and all those who work in health care. The Leading Health Care Example in this chapter describes one approach to building moral community in a range of workplace settings.

### Leading Health Care Example

**Exploring Ethics in Practice: Creating Moral Community in Healthcare One Place at a Time.**

Scott, Marck, and Barton (2011) describe an approach that they have used with nurses in practice to address the ethical issues that arise on a daily basis. The use of ethics in practice sessions (EIP) was developed in an acute care hospital in Alberta, but was subsequently adapted for community-based nursing in a rural home care practice setting and a rural public health nursing office in Alberta. These sessions are viewed as a way to build moral community as they provide a safe place for nurses, both practitioners and managers, to explore ethical issues using relevant research and the support of colleagues.

A group of nurses undertaking an EIP session drew on recent experiences to select one or more topics for discussion at the session. The group also identified colleagues who may be willing to present and discuss a topic, and the presenter could partner with a colleague from within the setting or from outside the setting. Managers provided support to the presenters who examined current policies and related literature and also developed one or more case studies to use in the presentation. The collected material, along with key questions, were provided to those who attended the EIP session, which lasted about 45 minutes—a 15-minute presentation followed by a 30-minute discussion. Topics addressed in these sessions have ranged from handling mistakes in practice, to triage in the emergency room, to small town practice. In their article, the authors describe an initial EIP discussion among rural public health nurses, who shared their stories and began to identify ethical concerns that they shared. A key one for these nurses was the blurring of boundaries between professional and personal lives and how to deal with situations in an ethical way when nurses lived in the community with their clients. An experienced public health nurse co-led the presentation that involved describing the problem identified by staff, summarizing relevant articles, and presented the case of an influenza outbreak that was used as a meaningful one for this group of nurses to discuss ethical aspects of boundary concerns. The case gave rise to a range of ethical concerns that nurses shared with each other in relation to the implementation of the H1N1 vaccine. The sharing of these stories

(Continued)
ETHICAL LEADERSHIP

In Chapter 1 we described ethical leadership in terms of appropriate conduct or conduct consistent with ethical norms for personal behaviour and interpersonal relationships. Ethical leadership also involves promoting such conduct among followers. Scholars of leadership and organizational science became more interested in ethical leadership following major business scandals in the United States (Brown & Treviño, 2006; Reed, 2012). Questionable business practices and financial scandals affecting Canadian health care have been reported in the press and have ranged from alleged excessive expense accounts of health care executives ("Alberta Health expense scandal," 2012) to alleged fraud in the building of a superhospital in Montreal (McArthur & Montero, 2012) and out-of-control spending and the awarding of untendered contracts for the development of electronic health records in Ontario by eHealth Ontario ("EHealth scandal a $1B waste," 2009). Despite high profile scandals in the media, several U.S. studies of employees in organizations rate ethical leadership quite highly (Brown & Treviño, 2006).

Brown and Treviño reviewed the literature on ethical leadership to address the question: What is ethical leadership? They identified the ways in which ethical leadership was similar to and different from the theories of authentic leadership, spiritual leadership, and transformational leadership (discussed in Chapter 1 of this text). All three types were similar to ethical leadership in terms of an emphasis on altruism (concern for others), integrity, and role modelling. However, authentic leaders are characterized by authenticity and self-awareness, whereas ethical leaders focus on moral management and awareness of others. Spiritual leaders focus on hope and faith as well as work as vocation more than the moral management approach.

Nurses who participated in the EIPs evaluated the sessions very positively. They learned from hearing about different approaches and thought that they would be able to incorporate some of what they heard into future practice situations. The authors emphasize the importance of participants identifying the issues for discussion and have found that such sessions can foster the growth of a "moral community" where moral imagination can develop in a safe, trusting environment.

Transformational leaders focus on vision and values whereas ethical leadership emphasizes ethical standards (Brown & Trevino, 2006).

There is considerable overlap between values-focused theories of leadership with respect to the ethical character and behaviour of leaders, with some differences in the overall approach to leadership. The idea of ethical leadership includes a more explicit focus on influencing others by establishing explicit ethical standards and holding followers accountable through reward and discipline, a style considered more transactional than transformational. This moral management style is similar to the approach used by regulatory bodies that set standards and can apply sanctions if there are violations of these standards. Transformational leadership style involves more personal qualities in a leader who is inspirational, charismatic, or intellectually stimulating and uses idealized influence (as discussed in Chapter 1).

**Ethical Leaders**

How do ethical leaders develop and how does one recognize ethical leadership in their work setting? According to Brown and Treviño (2006), there are influences in the development of ethical leaders: an ethical role model that a leader has worked with closely during his or her career, working in a positive ethical climate or culture that supports and promotes ethical behaviour and practices, and facing and dealing with morally intense situations in a workplace. Morally intense situations are those that have potential for great harm, and these are the situations that are apt to draw attention to the behaviour of a leader. If the leader handles these events in an ethical manner, he or she will be judged by others as an ethical leader. Ethical leadership theory proposes that ethical leaders influence the conduct of followers and the ethical decision making of these employees through role modelling and communicating the importance of ethical standards. Because followers will be held accountable for decisions, they will be more apt to consider the ethical implications of their decisions, leading to more ethical decisions.

A number of organizational scholars have focused on the role of **character** in ethical leadership, a focus that is reminiscent of the discussion in Chapter 1 of Great Man theories or trait theories of leadership (Hannah & Avolio, 2011a, 2011b; Quick & Wright, 2011; Wright & Quick, 2011). It is interesting to note that the founding editor of *Nursing Ethics* summarized a decade of nursing ethics (2000 to 2010), as reflected in that journal, and noted that “Virtue ethics is now definitely the theory of choice” (Tscudin, 2010, p. 130). The return to the notion of character as critical in leadership in organizations is relatively recent and is likely a reflection of concerns about the lack of ethical leadership evident in media reporting of high-profile scandals. Wright and Quick refer to character as morally based values, noting that character-based leadership is focused on qualities aimed at the betterment of society, as well as personal qualities aimed at the improvement of individuals. Values-based leadership has a wider focus than character-based leadership, because moral values are only a subset of a wider range of values, for example, competence, pleasure, comfort, and so on. According to Wright and Quick:

… a character-based leader is best viewed as an agent for moral change … one with the requisite self-control (moral discipline) to selflessly act on their own volition.
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(moral autonomy) to inspire, sustain and transform the attitudes and beliefs of both themselves and their followers. Best viewed as providing an overarching moral compass, the character-based leader has the perspective to continuously strive to move their team or organization beyond narrow, self-interest pursuits toward the attainment of common good goals (moral attachment). (p. 976)

There is agreement among some scholars about the concept of character, for example, that character refers to a moral component that is distinct from values (which have a broader range than moral matters) and from personality (which may include non-moral traits such as creativity) (Hannah & Avolio, 2011b). They also agree that character is something that can be developed and that it resides within the leader, is affected by context, and that some strengths of character (for example, courage) may fit specific contexts (for example, bravery in a firefighter). According to Hannah and Avolio (2011b), ethical behaviour and leader character might be expanded beyond the normal considerations, so that similar to performance on a continuum, behaviour may range from unethical to ethical to virtuous, and character may range from low to high to ethos. Ethos is described as “… an inner strength driving virtue … a distinct class of character—a class that when possessed by an individual will provide the inner strength or resources to step up and perform extra-ethical, virtuous action” (p. 991). To illustrate virtue, they cite the example of extreme dedication in a nurse to a patient when required by the context. The Canadian experience of nurses who cared for patients with Severe Acute Respiratory Syndrome (SARS) when there was great uncertainty about the illness illustrates virtue (see Campbell, 2006). Hannah and Avolio also believe leaders operating under extreme contexts (high moral intensity) require high levels of character, individuals are influenced by group members, and groups develop collective norms.

ETHICAL LEADERSHIP IN NURSING

All nurses are expected to practise in accordance with the ethical standards and guidelines that are explicitly set out by the regulatory body to which the nurse is accountable. For example, one might expect registered nurses in Prince Edward Island to adhere to the Code of Ethics for Registered Nurses of the Canadian Nurses Association (CNA) (2008), as the Association of Registered Nurses of Prince Edward Island (2011) has adopted that code in their Standards for Nursing Practice. However, although a code provides guidance, it cannot address every situation, and the code authors recognize that “practice environments have a significant influence on nurses’ ability to be successful in upholding the ethics of their practice” (CNA, 2008, p. 4). They also identify other key influences on ethical practice: other health-care practitioners, organizations, and government policy-makers. All nurses are encouraged to work with nursing colleagues and others to create moral communities that promote ethical care (CNA, 2008). As nurse managers and nurse executives are in key positions to influence the practice environment, leadership in ethics is expected of those who occupy such administrative positions (American Nurses Association, 2009; CNA, 2010).

We have much evidence from research in nursing that nurses experience moral distress due to external constraints (Corley, 2002; Pauly et al., 2009; Rittenmeyer &
To a somewhat lesser extent, researchers have identified what helps or does not help nurses in practising ethically and what nurse leaders can do to promote an environment that supports ethical nursing practice. An example is a qualitative study using focus groups that examined the meaning of ethics for nurses providing direct care (Rodney, Varcoe et al., 2002). In total, 19 focus groups were conducted involving 87 nurses from a variety of settings. The researchers used the metaphor of navigation on the water to describe their finding that nurses sought to reach the “good” in harmony with patients, families, and teams, which was not always easy: “they were navigating towards a moral horizon, but their course was often not smooth or certain” (p. 80). The nurse participants in the study described how their practice was helped or hindered in moving toward a moral horizon. Factors that constrained them included a culture that emphasized biomedicine over supportive time with patients and workplace efficiency over patient well-being. Several factors helped nurses with ethical practice: nursing colleagues and practitioners from other disciplines who were supportive, guidelines and policies that improved practice, and ethics education. The “currents” that affected navigation toward the moral horizon are listed in Box 14.2

Based on the study, Storch et al. (2002) identified the findings that were of particular relevance to nursing leaders. They noted three areas of concern to practising nurses that called for moral leadership:

- The climate and policies of organizations—nurses need to be able to raise ethical questions and not feel that they are silenced. In addition, policies that are lacking, too restrictive, or problematic for nurses in ethical situations need to be addressed.
- Allocation of resources was a concern, either because resources were wasted at times in maintaining life support when treatment seemed futile, or workload and understaffing prevented time to listen to patients or to reflect on ethical practice.
- Power inequities in the health care system created conflicts between loyalty to patients or to senior nurses and physicians. The imbalance in health care hierarchy might mean that nurses were excluded from decision making or were unable to get morally distressing situations addressed.
Addressing these concerns in a health care organization requires moral leadership among nurse leaders. Nurses in this study mentioned that nurse leaders, such as nurse managers, did not always provide support for nurses to address issues, raise questions, or advocate for clients, although there were some exceptions cited. Some nurses considered their managers as having little power themselves, but for the most part, these leaders seemed unwilling to take action. The researchers emphasized the need for nurse leaders to support nurses, act as moral agents, and make the point that these leaders might begin by self-reflection on what is preventing them from doing so. Then, they must help nursing staff identify the ethical issues, and in naming them, begin to address them. They need to find their moral courage and become a “moral compass” for nurses with whom they work (Storch et al., p. 12).

The sense that nurse managers as a group face challenges when addressing ethical issues was evident in a study by Gaudine and Beaton (2002) of nurse managers from seven hospitals. This qualitative study involved interviews with 15 managers. Four themes of ethical conflict between these managers and their organization emerged. These themes were:

1. voicelessness,
2. “where to spend the money,”
3. rights of the individual versus the organization’s needs, and
4. unjust practices by senior management or the organization.

These nurse managers experienced what could be considered moral distress and the researchers noted that:

it is difficult to convey the extent of the frustration, stress, pain, and powerlessness expressed in the interviews. The nurse managers shared the concern of their staff nurses when quality care could not be delivered, and they perceived themselves as the person responsible for improving patient care and for alleviating staff concerns.” (p. 28)

These findings have implications for hospitals and other kinds of health care organizations that need to attract and retain strong and effective leadership in nursing and retain strong and competent nursing staff.

Gaudine and Thorne (2009) examined the relationship between ethical conflict (as measured by perceptions of ethical value congruence with the hospital and shared ethical priorities) and adverse outcomes (using measures of stress, organizational commitment, absenteeism, intention, and turnover). In a sample of 126 nurses from one hospital, they found a relationship between perceptions of ethical disagreement and negative outcomes, underscoring the importance of organizations working to reduce ethical conflict in the workplace. In a subsequent analysis with a sample of 410 nurses in four hospitals, Gaudine and Thorne (2012) found three areas of nurses’ ethical conflict with their organizations:

1. patient care values,
2. value of nurses, and
3. staffing policy values.
In this longitudinal study of outcomes, they found that all of these areas were associated with stress, that patient care values conflict was associated with turnover when measured over one year, that conflicts around staffing policy values affected turnover intention, and that patient care values conflict predicted absenteeism. Nurses and nurse managers are not the only groups to identify conflicts with the organization in which they work. In a qualitative study of nurses and physicians in four hospitals, shared conflicts experienced by these two groups included lack of respect for professionals, insufficient resources affecting patient care and work life, clashes with organizational policies, administration turning a “blind eye” to problems, and lack of transparency or openness in the organization (Gaudine, LeFort, Lamb, & Thorne, 2011b).

There have been some encouraging examples and models for supporting nurses to “name” and address ethical issues that affect their daily practice. Storch, Rodney, Varcoe, et al. (2009) embarked on research to address how the ethical climate of the workplace can be improved for nurses in a three-year endeavour entitled, Leadership for Ethical Policy and Practice (LEPP). A description of this work is provided in the Related Research box at the end of this chapter. The next section also addresses some of the resources that nurses have reported as useful with respect to ethics in practice (Gaudine & Beaton, 2002; Rodney, Varcoe et al., 2002; Shirey, 2005).

ETHICS IN HEALTH ORGANIZATIONS

What is required of health care organizations with respect to ethics? If nurses and nurse managers are encountering ethical problems that do not seem to get resolved, what standards are in place that promote ethics and direct an organization with respect to ethical matters? Although nurses in Canada have reported moral distress and ethical concerns in practice, this seemed to be particularly intense during the aftermath of cutbacks and workload increases in the 1990s (Gaudine & Thorne, 2000; Rodney, Varcoe et al., 2002). Since that period, there seems to have been greater attention given to ethics within organizations. According to Gibson (2012), there has been a “dramatic increase in attention paid to ethics in Canadian health institutions” in the past 10 years (p. 37).

At the national level, there have been some steps taken to promote ethics within Canadian health care organizations. Accreditation Canada (2010) developed new standards that were introduced in 2008, and health care organizations that pursue the voluntary program of accreditation examine their own organization in terms of those standards, prior to a site visit by external reviewers. Although the program is voluntary, the majority of hospitals and increasing numbers of institutional and community-based services that employ nurses are undergoing accreditation. The revised program, called Qmentum that was introduced in 2008, has a greater focus than the earlier one had on quality improvement and patient safety (Accreditation Canada, 2009). Standard 5 under the section on “Effective Organization” requires the organization’s leaders make decisions consistent with the stated values and ethics that they have defined. These standards also indicate that the leaders “develop and implement an ethics framework” (Accreditation Canada, 2010, p. 7). The ethics framework defines the formal process for managing ethical issues, and includes a process for reviewing the ethics of research conducted in the organization. The organization’s leaders must identify who monitors the ethics framework and the processes for ethics,
and they must also develop and improve the ethics knowledge of all the players—board of governors, leaders, staff members, and service providers. In 2009, Accreditation Canada held a national conference on Ethics in Health Care “showcasing the tools and strategies organizations need to deal with sensitive ethical issues that arise in health care” (p. 6).

Accreditation Canada mentions several kinds of issues that might be addressed by an ethics framework that a health care organization develops and adopts. One guideline reads: “The ethics framework may address issues related to organizational ethics, research ethics, clinical ethics, and bioethics, as applicable” (Accreditation Canada, 2010, p. 7).

**Organizational ethics** are typically distinguished from **clinical ethics** in that clinical ethics focuses on issues that arise for patients and providers in the provision of health care. An ethical situation that recurs may give rise to an organizational policy, for example, a policy on how decisions about resuscitation should be made and documented. However, organizational ethics generally refers to administrative and management ethical issues, including standards of business practice, the treatment of employees, resource allocation and management, and leadership practices that promote a positive moral climate within the organizations (Gibson, 2012; Keatings & Smith, 2010; Suhonen, Stolt, Virtanen & Leino-Kilpi, 2011). **Research ethics** refers to the policies on ethical review and monitoring of health care studies that are conducted within a health care organization. Some system of review of research proposals is established by organizations to ensure that such issues as consent, consideration of benefits and burdens, and scientific merit are addressed before approval to proceed with research is provided by an organization.

**Ethical Resources in the Workplace**

Health care organizations are apt to vary in what might be available in the workplace with respect to ethics resources. At a minimum, a health care organization or regional health service will have some statement of vision, mission, and values that can provide broad ethical direction for the services provided by that organization (Accreditation Canada, 2010). As an example, Box 14.3 contains this kind of statement from the Horizon Health Network in New Brunswick, which is a regional health care organization composed of hospitals, health centres, home care, public health, and other services in the province. As you can see, value statements typically contain a mixture of ethical and other kinds of values.

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**Box 14.3**

**Horizon Health Network Strategic Directions**

<table>
<thead>
<tr>
<th>Our Vision:</th>
<th>Leading for a Healthy Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Mission:</td>
<td>Care for People, Educate, Innovate and Foster Research</td>
</tr>
<tr>
<td>Our Values:</td>
<td>Compassion, Respect, Integrity, Collaboration, Excellence, Sustainability, Innovation</td>
</tr>
</tbody>
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**Source:** Reprinted by permission of Horizon Health.
Some of the other ethics resources that may provide useful guidance in health care organizations are discussed next.

**Ethical Guidelines and Codes of Ethics**

Some organizations may adopt a Code of Conduct or a Patient Bill of Rights that provide patients/clients and employees with statements about ethical conduct and standards that are expected in the organization. For example, hospitals with a religious sponsor may adhere to a specific code, such as the Health Ethics Guide of the Catholic Health Alliance of Canada (2012). However, in most health care organizations, practice is guided by the codes of ethics of the various health professions, because members of regulated health professions are accountable to their regulatory bodies, whether it is nursing, medicine, or physiotherapy, and to the standards set by the profession in the province or territory. For that reason, as a nurse, you should have a copy of your ethical guidelines or code of ethics that provides guidance for your practice. A copy might be available in your workplace, but these kinds of documents are easily accessed on nursing websites. Some national and provincial or territorial websites might provide additional ethical resources that are useful for the workplace. The section on Useful Websites will provide some sources for nurses in every part of the country; for example, there is a Canadian website on nursing ethics: [www.nursingethics.ca](http://www.nursingethics.ca/).

**Ethics Committees**

In some health care settings, there are ethics committees that have one or more functions related to ethical matters, but you are most apt to find these in large, acute care hospitals. In a 2008 survey of Canadian acute care hospitals with 100 beds or more, 126 responses were received for a response rate of 51% (Gaudine, Thorne, LeFort & Lamb, 2010). Approximately 85% of respondents reported having such a committee, with more than half of them established in the previous 10 years. These committees were advisory in nature, rather than making decisions about ethics, and the most common functions were education for committee members and health professionals (over 84%), counselling and support to health professionals (approximately 80%), and advising administration on organizational ethics issues (68%).

Ethics committees are typically interdisciplinary, with representation from such groups as nursing, medicine, and other health professionals, administration, law, ethics, clergy, board members, and so on. In addition to planning and organizing ethics education for the organization, some ethics committees provide consultation to health professionals and or patients and families with respect to clinical ethical issues in the hospital. Based on a case study of four Canadian hospitals, however, one might expect considerable variation in how hospitals handle ethics consultation. For example, in two settings in that study, a subset of the ethics committee offer consultations: one setting used an administrative-led ad hoc group, and one used a clinical ethicist who later reported briefly on consultations at ethics committee meetings (Gaudine, et al., 2011b).

There is some evidence that health professionals do not consult ethics committees when they are dealing with an ethical issue. In a qualitative study involving 34 nurses, 10 nurse managers, and 31 physicians from four hospitals, barriers to and facilitators to using
the committees by these professionals were identified (Gaudine, et al., 2011a). A common barrier was lack of knowledge about the committee and how it could be used, but some fear of the reaction of others was also identified, notably nurses’ concern about the chain of command. Physicians identified lack of expertise among committee members in medicine or ethics as a reason for not consulting ethics committees. Facilitators to using these committees included support within the unit and hospital by someone (a manager, ethicist, or patient advocate) and ethics education.

**Ethics Education**

Ethics education in health care organizations consists of a variety of approaches to raise ethical awareness and understanding among all those who work in or volunteer in those settings. As mentioned earlier, these endeavours are often the responsibility of an ethics committee, especially in large organizations, and may take many forms: a specific portion of orientation programs for new employees; luncheon seminars or discussion groups focused on an ethics scenario or ethics topic; ethics rounds wherein a real case situation is presented and discussed by those who were involved; and ethics workshops and conferences hosted by an organization or for which some employees are funded to attend. Nurses welcome activities designed to support learning about ethics (Storch, et al., 2009). The Ethics in Practice sessions discussed in the Leading Health Care Example in this chapter incorporated ethics education, but rather than something planned for a whole organization by an ethics committee, a group of nurses in a work setting choose the issue of greatest relevance to their practice for study and discussion (Scott, Marck, & Barton, 2011). In these sessions, the nurse leader identified relevant articles for the group participants to read. This activity is similar to the practice of ethics journal clubs in which nurses meet as a group on a regular basis to discuss a journal article on ethics.

**Clinical Ethicists/Clinical Ethics Services**

Clinical ethicist or bioethicist roles have developed since about the 1980s and these kinds of positions are most often found in large teaching hospitals. The ethicist is an individual with graduate preparation in philosophy, ethics, bioethics, or health care ethics, and typically, part of the preparation for the role is a placement or internship in a health care setting dealing with clinical or health care ethics consultation (Canadian Bioethics Society, 2008; Keatings & Smith, 2010). Health professionals from a variety of backgrounds pursue studies and a career in this kind of role, so you may meet clinical ethicists with a background in nursing or medicine. The role usually involves working with health care professionals, patients, and families to address issues and provide support for decision making in difficult situations. An ethicist employed by a health care organization provides ethics consultations, but also may be expected to plan and organize an ethics program or service that provides not only consultation, but also ethics education and advice on the ethical aspects of organizational policies and processes. For example, the Hospital for Sick Children (2013) in Toronto has a Department of Bioethics that “offers a consultation service for patients, families, and staff. This service is available to all patients, families, and health care practitioners who want help making difficult ethical decisions” (Hospital for Sick Children, 2013).
At several sites in British Columbia a three-year research study that focused on how nurses could improve the ethical climate in health care was conducted. The researchers planned this study based on the belief that "researchers, policy makers, administrators and health-care providers, through participatory democratic processes informed by ethical perspectives, can make critical changes to health care oriented to the good of patients" (Storch et al., 2009, p. 71). The project, Leadership for Ethical Policy and Practice (LEPP), was designed to involve nurses in direct practice, supported by formal nurse leaders, in developing and trying out strategies in daily work that promoted a positive ethical climate in the workplace. The overall project had a lead team, an operations team, an advisory group, and site project teams. Six site project teams were involved in the project, and they ranged from one part of a large health facility to an entire small hospital. The teams varied by site and were composed of direct care nurses and other health care providers with the support of the chief nursing officer (CNO) or equivalent.

The methodology for the study was participatory action research (PAR) as it is suited to looking at change and learning as the study unfolds. With PAR, participants are involved in determining the purposes, actions, data collection, and analysis of the study as the project proceeded, and therefore sites in this study were able to tailor the project to their situations. The site team participants met on a regular basis to share and discuss ethical concerns and problems in practice and to problem-solve solutions in their workplace. There were differences in site projects, but the overall study was overseen by the lead team and the operation team. All teams came together for an annual conference at which participants shared experiences and evaluated the progress of the study.

The authors identified what had been learned during the PAR study. Nurses at the different sites varied in their approach to addressing practice issues using an “ethics lens” and used strategies that fit with their unique situations. Strategies included ethics debriefings, integration of the ethics work with ongoing site projects, such as patient safety, or focused on interdisciplinary collaboration to resolve ethical challenges. Some site teams pursued and obtained research funding for their projects. Overall study findings identified by the authors included the following:

- the importance of nurses’ addressing their own issues in a practice setting
- nurses in formal leadership roles are key in supporting an ethical climate
- direct or indirect support of decision makers, Chief Nursing Officers (CNO), gave many nurses a sense of hope and connection to other nurses
- nurses valued the ethics lens, and PAR methods often provided them with new ideas about helpful actions

The authors acknowledge that PAR projects take considerable time and persistence to bring about changes and recognize the challenge of sustaining such projects. On the plus side, however, they note that there was considerable spillover from the projects and that knowledge transfer took place to other nursing groups and locations during the project.

SUMMARY

Your nursing career can lead you to work in a variety of health care organizations and settings, and you may notice differences in the moral climate and culture of these workplaces. Ethical reflection throughout your career will enable you to identify when and where you have enacted your moral agency and when you have experienced moral distress. The ability to recognize ethical issues and reflect on why you may feel constraints that prevent doing what you feel is the right thing to do are skills and practices that will serve you well. They will help you find your moral voice. Sometimes, just being able to “name” a problem or issue helps you consider what resources to draw on and how to seek a resolution in an effective way. In this chapter, you have been introduced to the idea of ethical leadership and character in ethical leaders. You will recognize such leadership in others and in yourself as you reflect on your practice. You will also play a role in building a moral community in your workplace as you seek to contribute to and promote a positive moral climate.

Glossary of Terms

**Character** refers to a multidimensional concept that includes moral discipline (personal needs are subordinated to the greater social good), moral attachment (commitment to something greater than yourself), and moral autonomy (discretion and judgment to freely act in a moral way) (Wright & Quick, 2011). Character implies habitual qualities to act in a moral way.

**Clinical ethics** refers to the standards that apply to clinical situations and issues in health care; these typically involve the practice of health care professionals and their concerns about care of patients/clients.

**Ethos** as described by Hannah and Avolio (2011b, p. 991), refers to “...an inner strength driving virtue ... a distinct class of character—a class that when possessed by an individual will provide the inner strength or resources to step up and perform extraordinary, virtuous action.”

**Moral agent/agency** refers to the ability to deliberate, choose, express, and act upon moral responsibilities. Nurses enact their moral agency when they reflect on and act in an ethical manner as they engage in professional practice.

**Moral community** refers to clear and shared values within a workplace that enable ethical action and discussion of ethical values and issues.

**Moral distress** refers to the negative feelings, such as anger and guilt, that are experienced when an individual acts contrary to his or her moral choice because of internal and/or external constraints.

**Moral/Ethical climate** refers to the prevailing values that influence a workplace or the health care system in general and that have an effect on professional practice within it.

**Moral/Ethical culture** refers to formal and informal systems in an organization that support either ethical or unethical behaviour. Examples include codes, ethical norms, leadership, policies, reward systems.

**Moral residue** refers to the lingering guilt or feelings that persist with unresolved moral distress or from acting in a way that is inconsistent with moral values due to choice or external constraints.

**Organizational ethics** refers to the ethical issues and standards related to
administration and management within an organization and how these influence organizational life; often this refers to the business aspect of a health care organization, human resource practices and the ethical aspects of decisions.

Research ethics refers to ethical standards for the conduct of research. Organizations establish some system for review of research proposals to ensure that they meet ethical standards and that ongoing monitoring is carried out, as required.

CASE

Danielle works on a medical unit that increasingly has patients who are drug users and who are hospitalized for treatment of other medical conditions. The nurses on the unit find that these patients are challenging to care for—their behaviour is sometimes aggressive and they frequently leave the unit. The nurses sometimes suspect they are seeking drugs and even using their IV lines for drug use. Danielle is concerned that the disapproval and dislike of these patients by colleagues might lead to care that is inadequate, and she sees this as an ethical issue. Some nurses complain to the nurse manager and to physicians and tell them that such patients should be treated on a psychiatric unit rather than a medical one.

Questions

1. Do you agree with Danielle that this situation raises ethical issues? If so, how would you describe these?
2. What role do you think Danielle could play in addressing this issue? What role do you think the nurse manager has regarding this issue?
3. What resources in the organization might contribute to addressing ethical issues in this situation?
4. How might such situations affect the ethical climate?
5. What do you think of the suggestion that these patients should be treated on psychiatric units?

Critical Thinking Questions and Activities

1. Reflect on a clinical experience in which you felt constrained to do what you thought was the “right thing” in providing care. What was it that caused you to feel constrained? Was there some aspect of the moral culture that influenced you?
2. Identify a formal or informal leader in your organization who you think is an ethical leader. Does this person demonstrate qualities that you think illustrate character? How has this person behaved that led you to identify him or her as an ethical leader?
3. Look for the formal values espoused in the organization in which you work. How many of these values do you consider to be ethical ones? Can you imagine a situation in which espoused values might conflict with each other? Have you seen evidence of one or more of these values
in the way the organization functions or makes decisions?

4. Investigate the ethical resources available in your health care organization. Informally survey your colleagues to see if they have used any of these resources to address an ethical issue.

5. Do you have a moral community in your work setting? If you think you do, identify what it is that makes you think you do. If you think you do not, what do you think you could do to promote building a moral community?

Self-Quiz

A registered nurse who is a staff nurse in a long-term care setting leaves work following the night shift after a patient died during the shift. The night shift was short-handed, and despite the nurse asking for a replacement nurse, the facility did not provide one. The nurse is feeling sad and guilty because her usual rounds were interrupted due to another resident’s seizures that took everyone’s attention, and she only discovered the death of her elderly patient when she resumed her rounds later. The following questions relate to this situation.

1. The feelings the nurse is experiencing are characteristic of:
   a. Institutional culpability
   b. Power imbalance
   c. Moral distress
   d. Ethical character

2. If the health care setting continues to emphasize controlling staffing costs, which causes nurses to feel as though the care of patients is compromised, it is likely to have a negative effect on:
   a. Transformational leadership
   b. Idealized influence
   c. Ethical disengagement
   d. Moral climate

3. A nurse manager who addressed this issue by drawing on the nursing code of ethics and standards to argue for improved staffing would be exhibiting which kind of leadership?
   a. Ethical
   b. Authentic
   c. Transactional
   d. Transformational

4. In health care settings, ethical issues related to staffing and human resources are considered to be matters of:
   a. Research ethics
   b. Clinical ethics
   c. Bioethics
   d. Organizational ethics

Useful Websites

Accreditation Canada
www.accreditation.ca/en/

Canadian Nurses Association on Nursing Ethics

Canadian Bioethics Society
www.bioethics.ca/
References


Hospital for Sick Children. (2013). *Department of Bioethics. Who we are*. www.sickkids.ca/bioethics/index.html


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