

CODE OF ETHICS FOR PAEDIATRIC NURSES

To discuss and outline way forward

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Νοσηλευτική Ηθική & Δεοντολογία

Nursing Ethics & Deontology

“If nursing ethics is a specific form of inquiry under the more general category of biomedical ethics, then any theory of nursing ethics will necessarily follow from biomedical ethics theory”

Ethical knowing is essential to nursing since the discipline has a moral obligation to provide service to society, and is responsible for conserving life, alleviating suffering and promoting health.

(Noureddine, 2001)

Ethical behaviour is not the display of one's moral rectitude in time of crises. It is the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions.

(Varcoe et al , 2004)

Judgements or decisions are justified by moral rules, which in turn are justified by moral principles that are more general and more fundamental than the rules.

(Thompson & Thompson, 1996)

Morals – Ἠθῆ (Ἠθος - Ethos)

- ⦿ An individual's own code for acceptable behavior
- ⦿ They arise from an individual's conscience
- ⦿ They act as a guide for individual behavior
- ⦿ Learned



Ethics (Ηθική)

- Ethics deals with the “rightness” or “wrongness” of human behavior
- Concerned with the motivation behind the behavior
- Bioethics is the application of these principles to life-and-death issues



Ethical Principles

- ⦿ Autonomy
- ⦿ Beneficence – Nonmaleficence
- ⦿ Justice
- ⦿ Fidelity
- ⦿ Confidentiality
- ⦿ Veracity
- ⦿ Accountability
- ⦿ ...



Ethical Dilemmas (Ηθικά Διλήμματα)

- Occur when a problem exists between ethical principles
- Deciding in favor of one principle usually violates another
- Both sides have “goodness” and “badness” associated with them



MORAL Model for Ethical Decision Making

- *Massage the dilemma. Define the issues. Consider the opinions of all the stakeholders and their value systems*
- *Outline the options. Examine all of the options good and bad.*
- *Resolve the dilemma. Review the issues and options, apply the basic ethical principles to each option. Decide the best option based upon the views of all stakeholders.*
- *Act by applying the chosen option. This step is usually the most difficulty because it requires actually implementation while the previous steps have been about discussion and dialogue.*
- *Look back and evaluate the entire process including the implementation. No process is complete without a thorough evaluation. Ensure that those involved are able to follow thru on the final option if not you may need to redo the process.*

Ethical Codes (Ηθικοί Κώδικες)

- These are formal statements of the rules of behavior for a particular group of individuals
- Ethical codes are dynamic
- Most professions have a “code of ethics” to guide professional behavior

Codes of Ethics for Nurses

International

[International Council of Nurses Code of Ethics for Nurses](#) (2005)

Australia

[Australian Code of Ethics for Nurses](#) (2008)

Belgium

[Belgian Code of Ethics for Nurses](#) (2004)

Canada

[Canadian Code of Ethics for Nurses](#) (2008)

Hong Kong

[Hong Kong Code of Professional Conduct and Code of Ethics](#) (2002)

United Kingdom

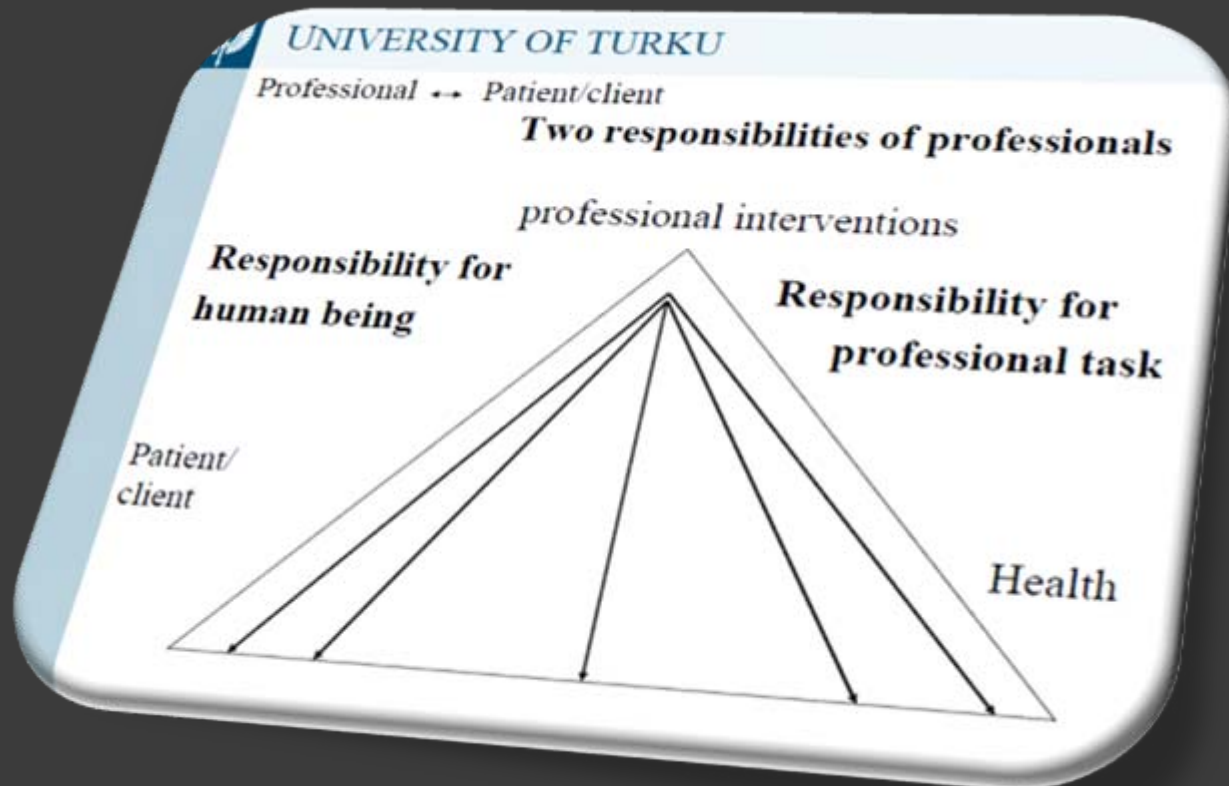
[Nursing and Midwifery Council's code of conduct](#) (2008)

United States

[US Code of Ethics for Nurses](#) (2001)

Two main types of ethics

- ⦿ A. Descriptive: **what is** right/good/wrong/bad?
- ⦿ B. Normative: **how to act** right/well/wrong/bad?



Ethical Codes in Nursing

European Perspective on Content and Functioning of Ethical Codes

www.zw.unimaas.nl/ecn/

Collaborators

- Universiteit Maastricht, The Netherlands (co-ordinator)
- Katholieke Universiteit Leuven, Belgium
- University Hospital of Wales, Cardiff, The United Kingdom
- University of Wales Swansea, The United Kingdom
- University of Turku, Finland
- Fondazione Centro San Raffaele del Monte Tabor, Milano, Italy
- National and Kapodistrian University of Athens, Greece
- Jagiellonian University, Krakow, Poland

Aims of international research project

- Identification of the moral values underlying ethical codes
- Identification of similarities and differences in content of ethical codes in nursing in Europe

The Value of Nurses' Codes: European nurses' views

- Nurses are responsible for the well-being and quality of life of many people, and therefore must meet high standards of technical and ethical competence.
- The most common form of ethical guidance is a code of ethics/professional practice; however, little research on how codes are viewed or used in practice has been undertaken.
- This study, carried out in six European countries, explored nurses' opinions of the content and function of codes and their use in nursing practice. A total of 49 focus groups involving 311 nurses were held.
- Purposive sampling ensured a mix of participants from a range of specialisms.
- Qualitative analysis enabled emerging themes to be identified on both national and comparative bases.
- Most participants had a poor understanding of their codes. They were unfamiliar with the content and believed they have little practical value because of extensive barriers to their effective use.
- In many countries nursing codes appear to be 'paper tigers' with little or no impact; changes are needed in the way they are developed and written, introduced in nurse education, and reinforced/implemented in clinical practice.

Barriers to use the codes

- *Slight awareness*
- *Unclear expressions of codes*
- *Lack of resources*
- *Lack of support of nurse manager*
- *Value conflicts with other health care professionals, relatives and organisation*

Code of Ethics and Conduct for European Nursing

Sasso L (FEPI) , Stievano A (Ipasvi), Jurado MG, Rocco G (Ipasvi)

- ⦿ A main identifying factor of professions is professionals' willingness to comply with ethical and professional standards, often defined in a code of ethics and conduct.
- ⦿ In a period of intense nursing mobility, if the public are aware that health professionals have committed themselves to the drawing up of a code of ethics and conduct, they will have more trust in the health professional they choose, especially if this person comes from another European Member State.
- ⦿ The Code of Ethics and Conduct for European Nursing is a programmatic document for the nursing profession constructed by the FEPI (European Federation of Nursing Regulators) according to Directive 2005/36/EC *On recognition of professional qualifications* , and Directive 2006/123/EC *On services in the internal market*, set out by the European Commission.

Code of Ethics for Nurses



Provision 1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

- [1.1 Respect for human dignity](#)
- [1.2 Relationships to patients](#)
- [1.3 The nature of health problems](#)
- [1.4 The right to self-determination](#)
- [1.5 Relationships with colleagues and others](#)

Provision 2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

- [2.1 Primacy of the patient's interests](#)
- [2.2 Conflict of interest for nurses](#)
- [2.3 Collaboration](#)
- [2.4 Professional boundaries](#)

Provision 3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

- [3.1 Privacy](#)
- [3.2 Confidentiality](#)
- [3.3 Protection of participants in research](#)
- [3.4 Standards and review mechanisms](#)
- [3.5 Acting on questionable practice](#)
- [3.6 Addressing impaired practice](#)

Provision 4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

- [4.1 Acceptance of accountability and responsibility](#)
- [4.2 Accountability for nursing judgment and action](#)
- [4.3 Responsibility for nursing judgment and action](#)
- [4.4 Delegation of nursing activities](#)

Provision 5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

5.1 Moral self-respect

5.2 Professional growth and maintenance of competence

5.3 Wholeness of character

5.4 Preservation of integrity

Provision 6. The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

6.1 Influence of the environment on moral virtues and values

6.2 Influence of the environment on ethical obligations

6.3 Responsibility for the health care environment

Provision 7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

7.1 Advancing the profession through active involvement in nursing and in health care policy

7.2 Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice

7.3 Advancing the profession through knowledge development, dissemination, and application to practice

Provision 8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

8.1 Health needs and concerns

8.2 Responsibilities to the public

Provision 9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

9.1 Assertion of values

9.2 The profession carries out its collective responsibility through professional associations

9.3 Intraprofessional integrity

9.4 Social reform

The Nursing Council of Hong Kong

Code of Professional Conduct and Code of Ethics

Eight aspects of professional conduct

In discharging his/her duty in a professional capacity, each nurse shall act, at all times, in such a manner as to:

1. Respect the dignity, uniqueness, values, culture and beliefs of patients/clients and their families in the provision of nursing care.
2. Hold in confidence personal information obtained in a professional capacity.
3. Safeguard informed decision-making and the wellbeing of patients/clients in the provision of care.
4. Provide safe and competent nursing care.
5. Maintain the agreed standard of practice.
6. Foster the trust that is inherent in the privileged relationship between nurses and their patients/clients.
7. Uphold the image of nurses and the profession by refusing advantages.
8. Practice in accordance with laws of Hong Kong relevant to the area of nursing practice.

End-of-life issues in paediatric intensive care

Ashok P Sarnaik

Kathleen L Meert

PAEDIATRICS AND CHILD HEALTH 17:3

Practice points

- Pediatric intensivists routinely face difficult end-of-life decisions
- End-of-life decisions should be consistent with the established ethical framework
- Assessment of the child's best interests can only be made with parental input
- Delaying attention to palliative care needs results in unnecessary suffering
- Management plans must be individualised according to each child's needs

- ◎ **Common end-of-life issues in paediatric intensive care:**
 - Is it ever morally acceptable to allow a child to die?
 - Is sanctity of life or quality of life the more important consideration?
 - Is there an ethical difference between withholding and withdrawing treatment?
 - Who should decide: physicians or parents?
 - Is euthanasia justified?
- ◎ **Dynamics of the decision-making process:**
 - poor communication among care providers and family members;
 - unavailability of parents and
 - disagreement over the care plan
 - support of the family unit,
 - communication with the child and family regarding treatment goals
 - ethics, involving shared decision making, relief of pain, continuity of care
 - grief and bereavement support.

End-of-life care in the pediatric intensive care unit: Attitudes and practices of pediatric critical care physicians and nurses

Jeffrey P. Burns, MD, MPH; Christine Mitchell, RN; John L. Griffith, PhD; Robert D. Truog, MD

Table 2. Clinician attitudes toward end-of-life care

	Physicians (%)	Nurses (%)	<i>p</i> Value
Percentage of respondents who agreed or strongly agreed with the statement: (on a scale where 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)			
"Withholding or withdrawing life support is unethical."	0 (1.15 ± .39)	0 (1.24 ± .43)	0.09
"Withholding is more ethical than withdrawing."	5 (1.67 ± .89)	18 (2.45 ± .99)	0.0001
"Withdrawing is more ethical than withholding."	7 (1.77 ± .99)	9 (2.51 ± .87)	0.0001
"Withholding and withdrawing are ethically the same."	78 (4.16 ± 1.06)	57 (3.43 ± 1.13)	0.0001
Percentage of respondents, in answering the question "How important are the following factors in influencing your decision on the extent of life support therapy to provide a patient?" who rated the following variables as important or very important (on a scale where 1 = not important, 2 = less important, 3 = neutral, 4 = important, 5 = very important)			
Quality of life as viewed by the patient	99 (4.60 ± .64)	99 (4.77 ± .42)	0.05
Quality of life as viewed by the family	95 (4.39 ± .72)	96 (4.49 ± .69)	0.24
Patient unlikely to survive	94 (4.08 ± .96)	91 (4.07 ± 1.00)	0.98
Potential for neurologically intact survival	81 (4.12 ± .85)	77 (4.33 ± .79)	0.06
Quality of life with a chronic disorder	61 (3.50 ± .99)	73 (3.85 ± 1.09)	0.009
Fear of litigation or breaking the law	23 (2.46 ± 1.12)	32 (2.91 ± 1.10)	0.002
Financial costs to society	13 (2.19 ± 1.00)	33 (2.82 ± 1.18)	0.0002
ICU bed availability	3 (1.32 ± .71)	4 (1.50 ± .85)	0.05
Percentage of respondents, in answering the question "If the circumstances for withdrawing life support are indicated, do you think the following medications should be added or increased in the patient's regimen as life support is discontinued?" who responded frequently or always to the following variables (on a scale where 1 = never, 2 = infrequently, 3 = sometimes, 4 = frequently, 5 = always)			
Narcotics	74 (3.96 ± .75)	86 (4.26 ± .69)	0.005
Benzodiazepines	62 (3.70 ± .72)	66 (3.84 ± .94)	0.15
Barbiturates	24 (2.70 ± 1.03)	27 (2.97 ± .97)	0.07
Neuromuscular blocking agents (e.g., Pavulon)	2 (1.28 ± .68)	2 (1.53 ± .81)	0.10

ICU, intensive care unit.

Percentages represent respondents who answered with scores of 4 or 5, on a 5-point scale shown. Numbers in parentheses are group mean scores ± so *p* values are for the comparison between physician and nurse responses by Wilcoxon rank-sums.

End-of-life care in the pediatric intensive care unit: Attitudes and practices of pediatric critical care physicians and nurses

Jeffrey P. Burns, MD, MPH; Christine Mitchell, RN; John L. Griffith, PhD; Robert D. Truog, MD

Table 3. Clinician reports of actual end-of-life practices in the intensive care unit

	Physicians (%)	Nurses (%)	<i>p</i> Value
In your experience, who usually initiates the discussion to limit life-sustaining treatment? (on a scale where 1 = never, 2 = infrequently, 3 = sometimes, 4 = frequently, 5 = always)			
Physicians	96 (4.05 ± .40)	86 (4.00 ± .53)	0.35
Nurses	28 (2.95 ± .78)	55 (3.41 ± .74)	0.0001
Family	4 (2.56 ± .56)	4 (2.61 ± .57)	0.56
Other (clergy, consultants)	1 (1.75 ± .61)	1 (1.79 ± .71)	0.86
Who else, if anyone, do you consult when making decisions about limitations of life support on patients in your PICU? (on a scale where 1 = never, 2 = infrequently, 3 = sometimes, 4 = frequently, 5 = always)			
Hospital legal representatives	6 (1.89 ± .80)	4 (2.08 ± .77)	0.05
Hospital ethics committee	8 (2.28 ± .85)	7 (2.46 ± .77)	0.20
Other clinicians from within the unit	66 (3.78 ± .91)	57 (3.54 ± 1.02)	0.09
Clinicians outside the unit	8 (2.27 ± .98)	9 (2.14 ± .93)	0.44
At the time that withholding and withdrawing life support is discussed, how would you rate the following areas as it is practiced in your unit? (on a scale where 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree)			
Families are well informed about prognosis	100 (4.86 ± .34)	97 (4.67 ± .61)	0.01
Families are well informed about the advantages and limitations of further therapy	99 (4.77 ± .48)	89 (4.47 ± .80)	0.003
The ethical issues for each patient are well discussed within the care team	92 (4.39 ± .69)	59 (3.80 ± 1.14)	0.0003
The ethical issues for each patient are well discussed between the care team and family	91 (4.40 ± .76)	79 (3.98 ± .91)	0.0002
If the family insists on continuing life support, even if the care team concludes that further therapy is futile, what is the usual response as it is practiced in your unit? (on a scale where 1 = never, 2 = infrequently, 3 = sometimes, 4 = frequently, 5 = always)			
We continue for a short time for them to reconsider, but then we terminate life support unilaterally	1 (1.21 ± .51)	3 (1.74 ± .87)	0.01
We continue for a short time for them to reconsider, but then we transfer care to another institution	1 (1.55 ± .70)	3 (1.56 ± .79)	0.79
We withdraw life support without the agreement of the family, after consultation with the hospital ethics or legal representatives	1 (1.21 ± .58)	0 (1.37 ± .55)	0.40
We continue to provide life support for as long as requested, and usually, through ongoing discussions, a consensus between the family and care team is reached	93 (4.17 ± .65)	88 (4.08 ± .68)	0.27
When life support is withdrawn, how involved is the physician in the actual process at the bedside? (on a scale where 1 = never, 2 = infrequently, 3 = sometimes, 4 = frequently, 5 = always)			
	100 (4.87 ± .34)	84 (4.35 ± .77)	0.0001

PICU, pediatric intensive care unit.

Percentages represent respondents who answered with scores of 4 or 5, on a 5-point scale shown. Numbers in parentheses are group mean scores ± SD. *p* values are for the comparison between physician and nurse responses by Wilcoxon rank-sums.

Toward interventions to improve end-of-life care in the pediatric intensive care unit

Robert D. Truog, MD; Elaine C. Meyer, RN, PhD; Jeffrey P. Burns, MD

(Crit Care Med 2006; 34[Suppl.]:S373-S379)



Table 1. Evidence-based suggestions for interventions to improve end-of-life care in the pediatric critical care unit (PICU)

Support of the family unit

- Increase opportunities for meaningful participation of parents in their child's care
- Maximize access of parents to their child while in the PICU
- Create a supportive network for the parents in the PICU while building bridges to support services that can continue after death

Shared decision making

- Develop interventions that promote better alignment between the information communicated by clinicians and the interests and needs of parents
- Develop interventions to ensure that parents have adequate control over medical decision making for their child, to both improve the process and to mitigate the risk of parental regrets
- Create opportunities for nurses to assist with decision making, thereby addressing nursing concerns that families are not well informed about their options
- Interventions based on determinations of medical futility are not likely to be helpful

Relief of pain and other symptoms

- Develop and assess protocols for the withdrawal of life support
- Develop and assess educational interventions focused on ethical principles related to end-of-life care, such as the doctrine of double effect and parameters for the use of neuromuscular blocking agents
- Let parents know that relief of pain is a priority for the child's care and educate them regarding how pain will be assessed, monitored, and treated

Ethics

- Develop and assess educational interventions focused on shared decision making with families to improve the quality of and promote consistency in end-of-life care
- Develop interventions to address the moral distress of clinicians related to perceived overtreatment of patients

Communication with the child and family about treatment goals and plans

- Develop interventions to increase availability and access of parents to physicians by liberalizing the means by which family-staff communication may occur, including e-mail, journals, and "office hours at the bedside"
- Develop interventions to tailor the communication style of the physicians to the preferences of the parents
- Develop experiential educational opportunities and support staff attendance at workshops to enhance the communication and relational skills of physicians and nurses

Grief and bereavement support

- Develop interventions to address parental grief and promote coping skills
- Develop bereavement support groups that better meet the needs of parents who have lost a child
- Enhance the availability of bereavement support groups to increase the participation of parents after the death of a child
- Encourage and support staff acts of kindness and commemoration during the bereavement period

MORAL DISTRESS OF STAFF NURSES IN A MEDICAL INTENSIVE CARE UNIT

By Ellen H. Elperin, RN, MSN, APN, CCNS, Barbara Covert, RN, BSN, CCRN

AMERICAN JOURNAL OF CRITICAL CARE,

November 2005, Volume 14, No. 6



Moral distress is psychological disequilibrium that occurs when the ethically right course of action is known but cannot be acted upon.

"I often equate my job with 'keeping dead people alive.' On these days, I dread coming to work."

Specifically, a number of nurses indicated that they had worried that their personal experiences of distress were unique and disproportionate to what other nurses experienced.

Table 2 Moral Distress Scale items associated with highest levels of moral distress

Item	Moral distress rating		Item score
	Intensity	Frequency	
Continue to participate in care for hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to "pull the plug"	5.57	4.63	25.79
Follow a family's wishes to continue life support even though it is not in the best interest of the patient	5.41	4.59	24.83
Initiate extensive life-saving actions when I think it only prolongs death	5.44	4.15	22.58
Follow the family's wishes for the patient's care when I do not agree with them but do so because the hospital administration fears a lawsuit	4.75	3.67	17.43
Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients	4.81	3.37	16.21
Provide care that does not relieve the patient's suffering because the physician fears increasing doses of pain medication will cause death	4.93	3.26	16.07
Carry out physician's order for unnecessary tests and treatments	4.00	3.07	12.28
Follow orders for pain medication even when the medications prescribed do not control the pain	4.15	2.81	11.66
Work with physicians who are not as competent as patient care requires	5.15	2.15	11.07
Prepare an elderly man for surgery to have a gastrostomy tube put in who is severely demented and a "no code"	4.07	2.67	10.87
Assist a physician who, in your opinion, is providing incompetent care	5.00	1.96	9.80
Work with nurses who are not as competent as patient care requires	4.63	1.78	8.24
Work with levels of nurse staffing that I consider "unsafe"	3.93	1.67	6.56
Work with nursing assistants who are not as competent as patient care requires	3.74	1.74	6.51
Observe without taking action when health care personnel do not respect the patient's privacy	3.46	1.77	6.12
Follow a family's request not to discuss death with a dying patient who asks about dying	3.78	1.59	6.01
Let medical students perform painful procedures on patients solely to increase their skill	3.00	1.81	5.43
Follow the physician's request not to discuss code status with a patient	3.41	1.59	5.42
Work with support personnel who are not as competent as patient care requires	3.37	1.59	5.36
Ignore situations in which patients have not been given adequate information to insure informed consent	3.56	1.44	5.13
Work with non-licensed personnel who are not as competent as patient care requires	3.00	1.59	4.77
Assist a physician who performs a test or treatment without informed consent	3.08	1.48	4.56
Follow the physician's request not to discuss code status with the family when the patient becomes incompetent	3.23	1.38	4.46
Give medication intravenously during a code with no compression or intubation	2.58	1.52	3.92
Increase the dose of intravenous morphine for an unconscious patient that you believe will hasten the patient's death	2.30	1.70	3.91
Carry out a work assignment for which I do not feel professionally competent	3.85	0.96	3.70
Ask the family about donating organs when the patient's death is inevitable	2.93	1.26	3.69
Not being able to offer treatment because the costs will not be covered by the insurance company	3.33	1.00	3.33
Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it	3.22	1.00	3.22
Discharge a patient when he has reached the maximum length of stay based on diagnosis related grouping (DRG) although he has many teaching needs	2.81	1.04	2.92
Follow the physician's order not to tell the patient the truth when he/she asks for it.	3.30	0.85	2.80
Ignore situations of suspected patient abuse by caregivers	3.11	0.81	2.52
Be required to care for patients I am not competent to care for	3.19	0.70	2.29
Follow the physician's request not to discuss death with a dying patient who asks about dying	3.56	0.63	2.24
Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	3.04	0.51	1.55
Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay	3.11	0.41	1.27
Provide better care for those who can afford to pay than for those who cannot	2.67	0.37	0.99
Respond to a patient's request for assistance with suicide when the patient has a poor prognosis	2.67	0.11	0.29

The Moral Distress Scale was created by Mary C. Corley, RN, PhD. Those wishing to use the scale must obtain permission via e-mail from Dr Corley (mccorley@vcu.edu).

The moral experience of parents regarding life-support decisions for their critically-ill children: a preliminary study in France

Franco A. Carnevale, Pierre Canouï, Philippe Hubert, Catherine Farrell, Francis Leclerc, Amélie Doussau, Marie-Josée Seguin and Jacques Lacroix
J Child Health Care 2006; 10; 69

◎ Ποιοτική έρευνα (Grounded Theory)

◎ Δείγμα ευκολίας

◎ Συνέντευξη

◎ 5 Κύριες θεματικές ενότητες:

- Ανάγκη για πληροφόρηση
- Υπεύθυνος για την τελική επιλογή
- Ανάγκη για μεγαλύτερη ικανοποίηση των αναγκών των παιδιών
- Μητρική ενοχή
- Ανάγκη για εκπαίδευση προσωπικού στην επικοινωνία με την οικογένεια

Table 1: Description of parent sample

Parent (n = 7)	Child's medical problem (n = 5)	Age when critically ill	Outcome
1 Mother 2 Father	A. Congenital heart disease	18 months	Death
3 Mother 4 Mother 5 Mother	B. Leukaemia C. Leukaemia D. Congenital heart disease	14 years 5 years Newborn	Death Death Living at time of interview
6 Mother 7 Father	E. Congenital heart disease and other anomalies	Newborn	Living at time of interview

PNAE: To discuss...

- ⦿ Does your country have a code of ethics?
- ⦿ Are you aware of its content?
- ⦿ Does it have direct references to pediatric nursing?
- ⦿ Do you have a professional code of conduct exclusively for pediatric nurses?
- ⦿ Do you think that pediatric nurses need their own code of professional ethics?

PNAE: ...to outline way forward

- ⦿ Collect data from each country!!!...how???
- ⦿ A list of “typical” ethical issues in clinical pediatric care (suggested by meeting participants)
- ⦿ A framework for “doing ethics”
 - Problem
 - Stakeholders
 - Facts
 - Alternative actions
 - Assessment of alternatives based on
 - ethical principles
 - Decision/ Recommendation/ Learning from decision

PNAE: ...to outline way forward

- Add to ICN Code or to FEPI's ?
- Draft statement on pediatric nurses ethical conduct?
- Proposals...

