FAITH AND ETHICS, COVENANT AND CODE

THE 2015 REVISION OF THE ANA *CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS*

BY MARSHA D. FOWLER

ABSTRACT: *How does and should the American Nurses Association* Code of Ethics for Nurses with Interpretive Statements, *with foundations from the late 1800s, impact today's nursing practice? How can the Code help you? The earlier 2001 Code was revised and became effective January 2015. The nine provisions received modest revision, as did the corresponding interpretive statements. However, Provisions 8 and 9 and their interpretive statements received more substantial revision. This article explains the Code and summarizes the 2015 revisions, considering points of particular interest for nurses of faith.*

KEY WORDS: *Code of Ethics, conscientious objection, covenant, creation care, ethics, evangelism, faith, nursing, religion, social ethics, spiritual care*

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The American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015) has a long, distinguished history. Beginning with a sizable body of ethics literature in the late 1800s, an official ANA Code followed some years after the Nightingale Pledge of 1893 (an oath written by Lystra Gretter). The Code has gone through numerous iterations, including the precursor codes of 1926 and 1940 (Fowler, 2010). The current (2015) Code consists of nine *provisions,* each with a set of *interpretive statements*. The Code is a *non-negotiable standard of ethics* for all nurses, in all venues, in all domains of practice. Unlike other standards, there are no "levels" based on levels of practice (ANA, p. 9). The Code is one standard, universally applicable to all nurses.

Over the decades, the interpretive statements for each of the provisions in the Code have moved from being descriptive and explanatory, to being normative. To clarify, the provisions have moved from explaining the meaning of the provisions or descriptions of how the provisions might be applied, to being normative statements of how the provisions *ought* to or must be applied. Thus, the nine provisions and respective interpretive statements, together, comprise the Code and are morally binding. The provisions are broad ethical statements, whereas the interpretive statements address particular practice issues and questions. Thus, the provisions need revision infrequently, whereas the interpretive statements begin to chafe and require revision approximately every decade.

THE 2015 REVISION PROCESS

The 2015 Code went through a process of revision, discussed here in highly abbreviated form. A task force decided whether a revision was necessary and concluded that the Code has stood up well, but Provisions 8 and 9 were most in need of revision. A group was formed to proceed with the revision. Drs. Marsha Fowler and Martha Turner were named as colead writers. The 2001 Code was posted openly online, and comments for change were solicited. Eventually, the proposed revision was posted, and additional comments solicited. Dr. Turner did yeoman's work in reading, collating, and categorizing over 8,500 comments. Her work then informed the writing. The broader committee reviewed and critiqued the revision, passed the final draft, and sent it to the ANA Ethics Advisory Board for approval. The ANA Board of Directors subsequently approved the Code, which went into effect in January 2015.

This article offers a brief overview of the 2015 revision of the Code, and consideration of points of contact for persons of faith. The reader is encouraged to have a copy of the current Code at hand (free at http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html). It is also useful to have a copy of the previous (2001) Code at hand for comparison. Space allows for highlighting some, rather than all, of the changes or the full content of each interpretive statement. (For a deeper discussion of the changes, see ANA's *Guide to the Code of Ethics with Interpretive Statements: Development, Interpretation and Application* [Fowler, 2015a]).

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THE CODE IS A *NON-NEGOTIABLE STANDARD OF ETHICS* FOR ALL NURSES, IN ALL VENUES, IN ALL DOMAINS OF PRACTICE.

In the interest of full disclosure, I have a long history with the Code. I served on the ANA Committee on Ethics, 1985 to 1989 (chair 1987–89); as a consultant to the revision of the 1985 Code; as a member of the Task Force for the revision of the Code, 1996 to 2001; as a member of the Task Force for the Review of the Code, 2012–13; as a member of the Steering Committee for the Revision of the 2015 Code, was named committee "Historian and Code Scholar," and colead writer of the 2015 Code. I've

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Conflict of Interest: The author was colead writer of the 2015 ANA *Code of Ethics for Nurses with Interpretive Statements*, and wrote *Guide to the Code of Ethics with Interpretive Statements* and *Guide to Nursing's Social Policy Statement* recommended in this article.

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devoted 35 years to the study of nursing ethics from the 1850s to the present. I believe nursing ethics to be distinguished, distinctive from bioethics, rooted in social ethics (Fowler, 2016), a source of pride-of-profession, and embodied, in part, in the *Code of Ethics for Nurses*.

GENERAL CHANGES TO THE CODE

The nine provisions of the 2001 Code were retained in the 2015 Code, with minor revision for clarity and incisiveness. Interpretive statements were reorganized to make sure that the sequence in the interpretive statement followed the sequence in the provision. There also was minor shuffling of content of the interpretive statements among the provisions to improve placement. An attempt was made to make the revision language *timeless*, that is, to avoid language that might become dated (necessitating another revision), as well as to make the language more direct and incisive, with greater use of formal ethical language and content. A new preface, introduction, glossary, and index were added. Weblinks were added to the digital version. In terms of substantive revision, Provisions 1–7 were modestly revised, whereas Provisions 8–9 received more dramatic revision because, to quote singer Bob Dylan, *The Times They Are a-Changin'*.

Changes in the times have necessitated the inclusion of new topics in the Code. Although these topics may be new to the Code, they are not new to nursing ethics literature. Books from the 1800s and early 1900s raise the issue of "the tone" of a school or hospital, specifically referring to the ethical environment—or lack thereof. Current concerns for moral distress, moral resilience, and the like, do not originate in the 2000s. In the late 1970s, my research marked a rise in "moral outrage," owing to ethics education among nursing students (Fowler & Mahon 1979). What we today call moral distress has been a concern for over a century, as well as virtually all the other ethical issues now being raised.

It is important to note that the *moral* concerns remain the same, even though technology and clinical practice have changed: *confidentiality* is *confidentiality,* whether related to 1800s' nurse–patient conversations or to today's computerized patient records. Heightened and new emphases in the 2015 revision are listed in Table 1.

TABLE 1: NEW EMPHASES IN THE 2015 REVISION OF THE CODE

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- Ethical practice environments
- Moral distress, incivility, bullying, mobbing, and workplace violence
- End-of-life care
- Research and evidence-informed practice
- Social media
- Genetics
- Nursing leadership and advocacy
- Interprofessional work and collaboration
- Nurses' voice in social justice and health policy
- The social determinants of health
- Nursing as a global, unified profession
- The global collaboration to address climate destabilization, violence, and other global threats to health

PROVISIONS & INTERPRETIVE STATEMENTS REVISIONS

For **Provision 1,** the full inclusiveness of the Code for all nurses in all roles and all settings, is emphasized. In addition, the line against prejudice or bias based on personal attributes, was hardened. With the increasing diversity of American society, it was important to explicitly name culture and cultural sensitivity as important to practice. The end-of-life section was further developed. The revision also heightened an emphasis on the nurse taking active leadership. These topics are not new to the Code but were refined in this iteration.

Provision 2 acknowledges that the patient may be an individual, family, group, community, or population. It specifically accounts for the fact that resources are not infinite, and that care is limited to available resources. Whereas previous versions of the Code had discussed conflicts of interest, this revision acknowledges that conflicts of interest occur in many roles and are not limited to financial conflicts of interest. The revision expands the content on gifts, to be less opaque and more direct concerning professional boundaries regarding gifts, bribes, dating, and sexual relationships with patients or co-workers. It also acknowledges differing cultural norms surrounding gifts and gift giving, again in a heightened awareness of the role of cultural norms in patient care in an increasingly diverse society.

Provision 3 now combines and sharpens the section on privacy and confidentiality. Provision 3 explicitly grounds protection of human participants in research, not only in respect for autonomy and patient self-determination, but also in a larger notion of respect

for persons. The section on informed consent is refined and includes the obligation of the nurse for *whistleblowing,* when patient rights or safety are jeopardized or violated, or where the clinical research is questionable. The previous version had a section on performance review that, in this revision, is moved to Provision 7. A section on *culture of safety* is added to this provision, with reference to errors and near-misses. This revision also makes clearer the process of addressing impaired practice.

In **Provision 4,** Advanced Practice Registered Nurses (APRNs) are specifically named. The provision is now explicit about APRN roles and *nursing orders.* The interrelationship of authority, accountability, and responsibility is better articulated, and the section on responsibility is clarified and expanded. In a concern to be inclusive of a wider range of nursing roles—and to name those roles—the section on assignment and delegation was expanded. For example, the responsibilities of the nurse educator in student assignment are now included.

Provision 5 focuses on the nurse's duties to self. This revision clarifies the wording in the provision, and reorganizes interpretive statements for consistency with the provision. The revision adds promotion of the personal health, safety, and well-being of the nurse; and clearly, decisively, states that nurses need never tolerate abuse. An uncomfortable statement was added that nurses should observe the same health-related behaviors that they research and teach to patients, that is, we ought to practice what we preach. The revision adds a section about the continuation of personal growth beyond what is required for professional performance, clarifying that, in the end, one cannot separate the personal from the professional moral identity. Though neither new, nor a change to the Code, conscientious objection appears in the Code under this provision.

Provision 6 enlarges the discussion of virtue and its relationship to the moral milieu that must exist for virtue to be cultivated and flourish. Within that ethical environment, one must inevitably come to a discussion of how nurses ought to treat one another. Here the Code expands the discussion of the characteristics of a morally good environment, beyond what had existed in previous versions. We also find a more direct and expanded discussion of ways to respond to a morally unacceptable environment.

Provision 7 is about the advance of the profession. This provision had, in earlier revisions, focused on research. The 2001 revision acknowledged that there are other means by which to advance the profession. This shift, however, resulted in a loss of the acknowledgment of the importance of nursing research to nursing's development. The 2015 revision reintroduces the emphasis on research, including scholarly inquiry. This provision also was changed to explicitly include all nurses, roles, settings, and the wide range of activities that advance the profession.

THE CODE EXPRESSES THE VALUES, OBLIGATIONS, AND IDEALS THAT FORM THE MORAL CORE OF NURSING... EACH NURSE MUST ALSO FIND A JUSTIFICATION WITHIN HER OR HIS OWN WORLDVIEW... FOR AFFIRMING THESE VALUES PERSONALLY.

Provision 8 is about collaboration, specifically to achieve the ends that cannot be achieved by one profession alone. Provision 8's roots are in the early statements focusing on the nurse–physician relationship; then when explicit mention of the physician was dropped from the Code, on the nurse's relationship with "other health professionals."

Provisions 8 and 9 received the greatest revision. Here we find a major revision to mandate collaboration, specifically for human rights, health diplomacy, and the reduction of health disparities. We also find, for the first time in our Code, a declaration of health as a universal right. This provision now hits hard on human rights and health disparities, introduces health diplomacy for the first time, and adds a new section on complex, extreme, or extraordinary practice settings, such as human-caused or natural disasters.

Provision 9 significantly advances the provision from 2001. The notion of the moral responsibilities of nurses collectively through their professional associations was first introduced in the Code in 2001. Provision 9, like Provision 5 on duties to self, was a new and contested provision, but over the years has come to find strong acceptance. It undergirds the professional association's involvement in healthcare and nursing legislation and policy. The 2015 revision heightens the integration of social justice in nursing leadership, organizations, and education; and takes a harder edge on nurses and nursing organizations' addressing issues of social justice, nationally and globally.

To fully appreciate the 2015 Code changes, it is perhaps best to examine the Code with the 2001 version in one hand and the 2015 version in the other. Successive revisions of the Code do not contradict one another. Instead, the revisions sharpen the focus of nursing's ethical obligations and, since the 1980s, have been more rigorous in the use of moral language and concepts. The

sidebar "What Do You Think? What Does the Code Say?" offers scenarios with application to the Code. Within the broader context of the Code, and not the changes alone, there are touchpoints of importance for the Christian nurse.

POINTS OF NOTE FOR NURSES OF FAITH

Values, Obligations, and Ideals: Several emphases in the Code will find resonance in many religions, including the Christian tradition. A few will be noted. For example, the Code affirms the "inherent dignity, worth, unique attributes" of each individual, and states that "the worth of a person is not affected by illness, ability, socioeconomic status, functional status, or proximity to death" (ANA, 2015, p. 1). The Code expresses the values, obligations, and ideals that form the moral core of nursing. This moral core has historical continuity throughout the 150-plus years of modern nursing. The Code does not (nor would it be appropriate to a Code), articulate a justification for these values, obligations, and ideals. Although nurses must affirm these values as a part of what it means to be a *good nurse* (good in a moral sense), each nurse must also find a justification within her or his worldview, life commitments, or faith tradition—for personally affirming these values. For Christians, the notion of persons having inherent dignity and worth can be extrapolated from an understanding of persons as created beings, made in the image and likeness of God. So, although the Code does not articulate the basis for the values it expresses, those values are not inconsistent with the Christian faith. Christian nurses will not find statements within this or previous iterations of the Code that conflict with Christian values.

Addition of Religion: Some of the 2015 changes to the Code are subtle, but nonetheless significant. One such change is the addition of *religion*.

Nursing's reconceptualization of *spirituality* as an ontological category, devoid of religious content, has been disingenuous. It fails to recognize the significant portion of the patient population, and nurses as well, who are persons of faith, who find religion and spirituality inseparable, and who embrace an explicitly religiously formed spirituality (Pesut, Fowler, Taylor, Reimer-Kirkham, & Sawatzky, 2008). For these persons, a concept of *spirituality* makes no sense except as understood as religious spirituality. For these persons, spiritual care must be *religiously-informed* spiritual care. Nursing's reconceptualization of spirituality as intrinsically nonreligious is subtly ideological, and serves, prejudicially, to deny religious persons the fullness of expression of their spirituality, thereby affecting their health and care.

> CHANGES IN THE TIMES HAVE NECESSITATED THE INCLUSION OF NEW TOPICS IN THE CODE REVISION.

In this Code revision, where spiritual needs are mentioned, care was taken to change it to "spiritual or religious needs." When nurses care for persons of faith, it is important that their care be based in an understanding of the patient's religion, and more specifically, how that religion views fundamental concepts, such as health, illness, suffering, care of the stranger (nursing), and community (Fowler, Reimer-Kirkham, Sawatzky, & Taylor, 2012). This is a far deeper understanding than a cursory knowledge of dietary law or religious practices. This level of understanding gets to the root of the patient's religious worldview as it interacts with health and illness (Fowler, 2009).

Nurses should also have at least a rudimentary understanding of the ethics of the religious tradition; the religious patient is better served by a religiously informed nurse (Fowler, 2006). Here, nursing curricula tends to fall short in introducing students to the academic study of religion (Taylor, 2012). As a final point, religious–spiritual care is not religious spiritual formation or spiritual development; it is care that is religiously informed in the patient's religion and seeks to discern the patient's intersections of religion and health/illness.

Conscientious Objection: Religion is mentioned regarding conscientious objection (ANA, 2015, pp. 21, 42). *Conscientious objection* is a conscience-based refusal, for ethical or religious–ethical reasons, to act or participate in an action that falls within the scope of one's practice and would otherwise be required (Johnstone, 2004, pp. 329–330). It may not necessarily protect a nurse from reprisal or dismissal. Historically, conscientious objection has been called *refusal to participate* or *refusal of orders* (physician's orders) and has been employed when the nurse (or nursing collectively) has a categorical objection to a particular intervention (e.g., abortion, transsexual surgery, hemicorporectomy, force-feeding prisoners, torture, capital execution, etc.); or objection to a specific intervention for a particular patient that the nurse deems inappropriate for the patient, or that the patient has refused.

Refusal to participate in specific interventions does not extend to refusal to care for persons who make health decisions with which the nurse disagrees, or whose lifestyle choices are not in accord with the nurse's personal values, or whose personal attributes evoke prejudices. "Nurses establish relationships of trust and provide nursing services according to need, setting

aside any bias or prejudice. Factors such as culture, value systems, religious or spiritual beliefs, lifestyle, social support system, sexual orientation or gender expression, and primary language are to be considered when planning… care" (ANA, 2015, p. 1). In patient care, nurses are responsible for nursing judgment and do not make judgments about patient choices or lifestyles.

Taking Life: In terms of specific interventions, the 2015 revision holds the line on nurse participation in taking human life. The Code does not say that it opposes euthanasia or assisted suicide, but that nurses should not participate. Society may, and in some states, has already chosen to authorize assisted suicide (and possibly, down the road, euthanasia). States' legal authorization does not address the moral question of whether physicians (or nurses) ought to participate in euthanasia or assisted suicide. Literature does not address the distinctive differences between medicine and nursing that might forbid nurses from participating in assisted suicide or euthanasia, even where physicians might choose to authorize it or participate.

The prohibition against the taking of human life has been a stringent norm in medicine and nursing and is embedded in the Nightingale Pledge of 1893, which was patterned after the Hippocratic Oath (Fowler, 2010). This norm is so stringent that it prohibits nurses from participating in legally authorized capital punishment. However, in the case of capital punishment, the ANA has taken a stand not only against nurse participation, but also against capital punishment per se (2016).

Christian traditions differ in how they state the norm that guides the taking of life, even as disease brings life's end near. In general, the understanding is that life is a gift and a loan, and that we are its stewards—and in the case of nursing, life's caregivers and stewards. In addition, Christians are guided by a norm that our lives are not our own to do with as we please; we

WHAT DO YOU THINK? WHAT DOES THE CODE SAY?

1. Mary cannot share her Christian beliefs at work because of "Separation of Church and State."

2. Tom was fired because he refused to follow a physician's order that he believed would jeopardize the life of a patient. He discussed this with the physician, who would not change the order, and Tom's request to change patients with another nurse was denied. Was his dismissal appropriate?

3. Julie is a Faith Community Nurse (FCN). The church pastor wants her to tell him who uses her services and what those individuals' needs are. How should she respond?

4. A fourth-semester nursing student complains he is required to perform care tasks that he is not ready to provide. However, the student was taught these tasks and demonstrated proficiency in the third semester. Who is at fault?

5. Susan just began working at a correctional facility and is told that part of her job is assisting with capital punishment should the situation arise. What should Susan do?—***JCN***

1. *False:* "When nurses are asked for a personal opinion, they are generally free to express an informed personal opinion…and preserve the voluntariness or free will of the patient" (ANA, 2015, p. 20).

2. *No:* "When a particular decision or action is morally objectionable to the nurse… the nurse is justified in refusing to participate on moral grounds…such refusal should be made known as soon as possible, in advance and in time for alternate arrangements to be made for patient care" (ANA, 2015, p. 21).

3. *Refuse:* "The nurse has a duty to maintain confidentiality of all patient information, both personal and clinical, in the work setting and off duty in all venues" (ANA, 2015, p. 9). The FCN may ask the client if she or he wants to be placed on the congregation's prayer list or to have the pastor advised of concerns; the client can ask the FCN to tell the pastor specific information, however, communication is limited to what the patient directs.

4. *The educator:* "Nurse educators in any setting should collaborate with their students to assess learning needs, to develop learning outcomes, to provide appropriate learning resources, and to evaluate teaching effectiveness" (ANA, 2015, pp. 16–17).

5. *Professional ethics requires Susan not to participate in capital punishment:* She should share the 2015 Code with her supervisors and request that other arrangements be made should this situation arise. If the facility is insistent that this is her job, she should contact ANA for assistance.

belong to God who numbers our days. Thus, the proscription about taking life extends to a prohibition against taking our own lives. Various Christian traditions will state this in somewhat different ways. This is a norm also found in Judaism and Islam.

Duties to Self: Provision 5 addresses the nurse's personal lifestyle. The nurse is enjoined to meet a range of obligations to self that collectively fall under an aggregate duty or principle of *duties to self*. These include the promotion of personal health, safety, well-being, wholeness of character, personal integrity, maintenance of competence, and continued professional and personal growth. In other words, nurses are to be good stewards of the gifts they have received, of their life and health. This is, of course, a duty that one has in living an obedient life, C*oram Deo en Cristo*, before God-in-Christ.

Wholeness of Character: A part of duties to self is the requirement to maintain *wholeness of character*. Nursing care is a most intimate activity. It is a fiction that such care could or should be conducted in a detached, dispassionate, uninvolved manner. Human care, nursing care, touches both the recipient and the caregiver interpersonally. Still, the nurse–patient relationship is a therapeutic relationship, a professional relationship, that some also regard as a *covenant relationship*. And, it is an authentic relationship, in which the nurse is to be who she or he truly is. The nurse who is a Christian is both nurse and Christian. The Code (ANA, 2015, p. 20) states:

> When nurses are asked for a personal opinion, they are generally free to express an informed personal opinion, as long as this maintains appropriate professional and moral boundaries and preserves the voluntariness of the patient. Nurses must be aware of the potential for undue influence attached to their professional role.

When a nurse is asked "Do you believe in God?" or similar questions, the nurse is free to give a personal answer (or not). This is not, however, permission to engage in evangelism, nor may the nurse manufacture or manipulate the situation to engage in evangelism.

Wholeness of Character and Evangelism: This section is intended to allow the nurse to be a whole person, to allow the nurse to respond with integrity to patient questions such as, "Do you have a faith?" It also permits the nurse to go further, if the patient invites, and to express the nature or content of her or his religious belief. What the section specifically does not permit is a general evangelistic intent in nurse–patient relationships. So, the question is, "what are the moral grounds for or against evangelism in patient care?"

THE CODE DOES NOT SAY THAT IT OPPOSES EUTHANASIA OR ASSISTED SUICIDE, BUT THAT NURSES SHOULD NOT PARTICIPATE.

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The nurse holds a *power position* in the nurse–patient relationship. This is somewhat like the power relationship, or more specifically the *power differential*, that exists between teacher and student, pastor and parishioner, physician and patient, warden and prisoner, or with other status individuals. Today, as nursing authority and power has grown, the nurse–patient relationship is intrinsically persuasive and intrinsically risks becoming unduly influential or coercive, providing opportunities to violate professional boundaries—particularly in the face of the existential anxiety that health crises can provoke. In the face of this power differential, patients are vulnerable and at risk of having their voluntariness constrained by that vulnerability. Ethics requires that patient voluntariness (freedom) be maintained.

Patients can be subject to internal constraints to voluntariness, such as anxiety, pain, chemical imbalances, sepsis, pain, and the like. In addition, the nature and threat of health crises make patients particularly subject to external constraints to voluntariness, including pressure, undue influence, coercion (fraud, deceit), and the like. Although internal and external constraints do not necessarily render a patient nonvoluntary, they do constrain voluntariness and can do so to the degree that the patient could make a decision inconsistent with, or perhaps even against, her or his wishes or values (Fowler, 2014).

Nurses must tread the path between persuasion and undue influence and, even further, coercion. They must wait for a patient's invitation or a free expression of openness, even within the context of a religiously based hospital. If the religious mission of the institution has been made clear and public, patients can and should expect to be exposed to the institution's faith

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tradition in some manner. However, the hospital serves the public within its catchment area, and admission to a specific hospital may be beyond the control of the patient. One tends to end up wherever the ambulance parks. So, although a religiously based hospital may have greater liberty in expression of its faith to patients through its healthcare professionals, and perhaps the right to more directly raise faith-based issues, the patient nonetheless retains the right to say "no." And "no" means "no." There is no open season on proselytizing patients. Furthermore, spiritual care is not to be interpreted as evangelism (Fowler, 2014; Taylor, 2011).

Social Justice: Provision 9, and to some degree Provision 8 (on collaboration to achieve larger ends), gives a harder edge to nursing's mandate for involvement in issues of social justice. This provision should be of special interest to Christian nurses. Provision 8 calls the nurse to "collaborate with others to change unjust social structures and processes that affect both individuals and communities. Structural, social, and institutional inequalities and disparities exacerbate the incidence and burden of illness, trauma, suffering, and premature death" (ANA, 2015, p. 32). It notes that "…genocide, the global feminization of poverty, abuse, rape as an instrument of war, hate crimes, human trafficking, the oppression or exploitation of migrant workers, and all such human rights violations" are of grave concern to nurses (p. 33). One should hear behind this the voices of the biblical prophets, especially Amos, as well as the full weight of the gospel. God hates idolatry and the oppression of the poor and calls Christians to care for neighbor, near and far, and reach out to a world that suffers. Nurses are particularly equipped to work with others to address the horrific range of human suffering that exists globally.

Social Justice and Creation Care: Provision 9 more directly addresses nurses' collective role in engagement with issues of social justice, particularly through professional nursing associations. The provision calls nurse educators to integrate social justice content in curricula, and the nursing profession to act upon concerns for social justice through participation in political processes and arenas. However, the provision goes beyond issues of human justice to that of *creation care*. It states, "Social justice extends beyond human health and well-being to the health and well-being of the natural world.… As nursing seeks to promote and restore health, prevent illness and injury, and alleviate pain and suffering, it does so within the holistic context of healing the world" (ANA, 2015, p. 37). This resonates with the ancient rabbinic (Mishnaic) Jewish concept *tikkun olam*, to repair the world. *Tikkun olam* is generally understood today as a call to social justice activism and social justice policy, to help the disadvantaged, to environmental concern, and to addressing the brokenness of the world. Although both are necessary, *tikkun olam* goes beyond a concept of *stewardship* (i.e., of faithfully preserving, maintaining, and caring for the earth and all that is therein), to actual repair of the whole of society and creation.

Web Resources

- 2015 ANA *Code of Ethics for Nurses with Interpretive Statements*—http://bit.ly/29K0nsj

Nursing's Covenant with Society: It is appropriate to close these considerations by noting that the Code acknowledges nursing's covenant with society. The Code does not elaborate on the notion of covenant; however, a larger discussion of the nurse–society relationship can be found in ANA's *Guide to Nursing's Social Policy Statement: Understanding the Essence of the Profession from Social Contract to Social Covenant* (Fowler, 2015b).

William May identified distinctions between a contract and a covenant (1975, pp. 34–35):

> Both include an exchange and an agreement between parties. But...contract and covenant are quite different. Contracts are external; covenants are internal to the parties involved. Contracts are signed to be expediently discharged. Covenants have a gratuitous, growing edge to them that nourishes rather than limits relationships.... There is a donative element in the nourishing of covenant—whether it is the covenant of marriage, friendship, or professional relationship. Tit-for-tat characterizes a commercial transaction, but it does not exhaustively define the vitality of that relationship, in which one must serve and draw upon the deeper reserves of another.

Nursing's covenant with society is a covenant of care. Although the *Social Policy Statement* has focused on nursing's social contract with society,

social contract is, in the end, an inadequate characterization of that relationship (Fowler, 2015b). *Covenant* more fully captures the nature of the nurse–society relationship.

CONCLUSION

The 2015 revision of the *Code of Ethics for Nurses with Interpretive Statements*, as have all the previous revisions, advances the ethics of the profession by renewing its applicability to contemporary practice; by greater clarity and specificity regarding nursing's obligations to society; by greater ethical incisiveness; and by continuing the long, complex, and capacious history of nursing's ethics. The Code is not a Christian document, and yet in this revision of the Code, nurses who profess a Christian faith will find points of contact with their faith that can be explored and developed. In doing so, Christian nurses can move toward a greater integration of personal faith and professional ethics.

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