Republic of San Marino

National Bioethics Committee of Republic of San Marino

Law n° 34 of January 29, 2010

PAIN MANAGEMENT NURSING: BIOETHICAL ASPECTS

APPROVED IN THE PLENARY SESSION OF MAY 15, 2017

Interpretation and Translation Service of the Department of Foreign Affairs

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INTRODUCTION

Discussing the topic of pain requires unique knowledge and establishes some difficulties in terms of comprehension and sharing.

The reason for this is that the experience of pain involves, without distinction, the person in his body, psyche and environment.

The evolution of scientific knowledge has contributed to a cultural enrichment by introducing the concept of care in the path which leads to a desired healing. In the oldest sense of the word, according to the meaning which Igino would have wanted to attribute to the original myth of *Cura*[1], man, as a mortal being, has the need for attention and accompaniment in order to provide for his own needs in every moment of his life.

In this holistic definition of the *cura*, that encompasses the suffering person and his family nucleus, treating pain becomes inevitably multidisciplinary and multimodal.

On the inside of this treatment team, the nursing role assumes a fundamental and unique position due to the proximity to the patient and his kin, often becoming the confidant and natural go-between with the physician.

The CSB has considered it appropriate to affront the problem of managing pain and suffering since the beginning of its mandate in choosing to elaborate a report which is completely centered on nursing care in order to underscore its high bioethical relevance.

This effort intends to bring its particular contribution to international bioethical consideration regarding pain which, although substantial, in smaller measure has dealt with this theme in the nursing prospective.

The choice of CSB in this sense has been the natural progression of a collaboration undertaken with the AIS (Associazione Infermieristica Sammarinse: San Marino Nursing Association) following the request of this Association to activate a partnership and to receive a support for the underwriting of its Code of Ethics, the first in San Marino nursing history, approved by the CSB in the March 13, 2017 session.

Following the considerations brought forth in these work sessions with representatives from the AIS, the CSB decided to elaborate upon the dissertation of nursing care regarding pain, a subject which nurses have shown a particular sensibility and which a specific article within the Code of Ethics has been dedicated:

“The nurse shall strive to prevent, monitor, and alleviate a person’s pain and suffering utilizing all necessary treatments”(art.23).

This document intends to bring into focus the distinctive features of the nurse's role within the multidisciplinary team by recommending a specific and continuous education in this sector which permits the nurse to implement an integrated evaluation of pain, recognizing the subjective component, and attributing to his/her care an urgent clinical priority.

Such education must allow nurses to approach the patient and his/her family in contributing to fostering adequate communication and allowing the person to be truly aware of the relative risks and benefits.

The document dedicates particular attention to nursing care in *liminae vitae*, defining with clarity some concepts of particular complexity such as that of discontinuation, extraordinary life saving measures, and therapeutic abandonment in order to guarantee to each patient the respect of the principle of autonomy and to the multidisciplinary team a correct allocation of resources.

Among the concluding recommendations the CSB remarks upon the necessity of guaranteeing the nurse a continuous support, even within the team, with the goal of preventing burnout considering the emotional impact involved in accompanying the sick person in his/her care.

The document is enriched by an attachment which describes the history of the nursing profession in the Republic of San Marino.

The work group, established in October 2016, was coordinated by Dr. Nicolino Monachese and by Vice president, Professor Luisa Borgia. Also joining were Professor Carlo Bottari, Professor Adriano Tagliabracci and Doctor Salvatore D'Amato (in the role of external expert to the CSB). The group also availed itself of the contribution of Dr. Stefania Ansaloni.[1]

The CSB would like to thank the Presidency of IPASVI Italy (National Federation of Nursing Colleagues) which, with the proxy of Dr. Laura D'Addio, accepted the invitation for the preliminary hearing of the operations during which important points to consider originated.

The CSB also wishes to thank Dr. Marina Minutillo for the translation of the introduction end technical terminology.

The document was unanimously approved in the May 15, 2017 session of the CSB by those present: Luisa Borgia, Carlo Bottari, Carlo Daniele, Nicolino Monachese, Monica Tonelli, Verter Casali, don Gabriele Mangiarotti, Francesco Carinci and Renzo Ghiotti. Those absent from the session, President Virgilio Sacchini, Adriano Tagliabracci and Giorgio Cantelli Forti communicated their acceptance.

Vice President CSB
And President of the Same in the Session of May 15, 2017
Luisa Maria Borgia

FOREWORD

Since 1986, the World Health Organization, in noting that pain can be alleviated in more than 90% of patients with a simple and systematic approach, has proposed guidelines modulated according to the intensity of pain to be treated (three scales which provide, at the lowest intensity level, for non-opioid drugs, NSAIDs, weak opioids and then strong opioids, accompanied by adjuvants).

It has also urged governments to ensure the availability of analgesics and to review controls on opioids to make them actually available in the necessary quantities.

A research study conducted in 16 European nations, which interviewed more than 46,000 people in order to investigate the prevalence, severity and treatment of chronic pain and its impact on daily life, highlighted that pain in Europe is a devastating and widespread problem. At least 75 million people - one out of every 5 adults – do not have the possibility to exercise their right to effective treatment. The variety of behaviours is as impressive as the total number of people forced to endure pain they would rather not experience and which could be easily relieved [1].

Nonetheless, pain is still one of the most common reasons why people seek the assistance of a healthcare professional.

Given the importance of this issue, which nurses are faced with every day in their daily activities, and the impact that pain has on the psychological and physical health of the patient, it is a primary professional objective for nurses to be able to make an integrated assessment of pain.

It is therefore clear that nurses should have specific skills in managing pain and suffering.

As a consequence, the assessment and treatment of pain must be part of the culture of any healthcare professional, so that all members of a multidisciplinary and multi-professional team are able to make their own contribution, based on knowledge, skills and specific responsibilities attached to their role.

In medicine pain relief has always been an objective to be jointly pursued by healthcare professionals and patients. However, while in traditional medicine pain was only a symptom of disease, in modern medicine pain has changed its *status* and has become a disease in and of itself.

This document is not aimed at considering the interconnections between pain and religion (break of the link among pain, guilt and atonement), between pain and biology (pain as a useful, but sometimes counterproductive signal) and between pain and psychology (relationship between pain and suffering,

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[1] Breivik H, Collett B, Ventafridda V, Cohen R, Gallacher D., Eur J Pain. 2006 May;10(4):287-333. Epub 2005 Aug 10. *Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment.*

both physical and mental) but that of reaffirming that the fight against pain, understood as a mental and physical disease, falls within the primary tasks of medicine and society [2].

This has required a multidisciplinary approach to pain medicine, recognising pain as the "fifth vital parameter"[3], and a continued commitment of the scientific community to ensure that all healthcare professionals treat pain by using the means available to them in order to improve the quality of life of patients.

This approach in treating pain has been developed by healthcare specialists in anaesthesiology since the Second World War principally due to the need of analgesia during and after a surgical operation. Subsequently, this approach has also been applied to cancer patients.

At that time, these were the two main areas where medicine was used to effectively relieve pain as a "symptom".

The development of neuroscience in the twentieth century, flanked by the evolution of medicine and surgery, generated increased interest in this issue.

The *International Association for the Study of Pain* (IASP) was established in 1973 and held its first World Congress in Florence in 1975. In 1976, its Italian chapter, i.e. the Italian Association for the Study of Pain (AISD), was set up and in 2008 the San Marino Association for the Study of Pain (ASSD)[4] was created as the national IASP Chapter of the Republic of San Marino.

Over the past forty years the evolution of pain medicine has been constant, with an increasing number of clinicians worldwide interested in this discipline including the participation of all medical specialties which, though not dealing exclusively with the diagnosis and treatment of pain, are engaged daily in providing care to patients with painful diseases.

As a consequence, many health disciplines have focused part of their training on pain treatment by establishing new objectives and *modus operandi*.

Contemporary medicine bases its approach to pain on some paradigms:

- the recognition of pain as a "disease";

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[2] Italian Committee for Bioethics, *Pain therapy: bioethical guidelines,* Presidency of the Council of Ministers, Rome, 30 March 2001 (http://bioetica.governo.it/en/icb-work/the-opinions-and-responses/2001/).

[3] With arterial blood pressure, heart rate, respiratory rate and body temperature.

[4] www.assdolore.org

- the objectification of pain with parametric tools;
- a multi-modal and multi-professional approach of the teams taking care of patients with pain.

The international scientific community today recognizes the value of a bio-psycho-social, multidisciplinary and multi-professional approach to people with pain.

THE ROLE OF NURSES IN THE MULTIDISCIPLINARY ASSISTANCE TEAM

Nurses can play a key role in managing pain using current knowledge of the measures to attenuate it and through adopting best practices for its assessment and management.

Over the years, the transformation of science from "Pain Therapy" (mainly based on drugs and non-pharmacological techniques to relieve the symptom) to "Pain Medicine" (aimed at multidisciplinary diagnosis and treatment of chronic painful illnesses, regardless of their origin) has led to the paradigm that the patient should not (and cannot) be evaluated solely from a "biological" point of view when the intention is to treat a painful disease. Pain, by definition, is indeed both a *sensory* and an *emotional* experience and therefore we also need to deeply know the *psychological* and *social* aspects of the assisted persons, the context in which they live and the repercussions that the disease has on their lives. It would not otherwise be possible to identify the most effective and appropriate treatment for each individual patient.

In order to be practically implemented, this approach requires commitment and competence by the entire health care team assisting the patient. In this regard, each professional (doctor, nurse, psychologist, social worker, etc.) shall have a specific area of intervention, following an integrated assessment of persons in their entirety and not only in relation to some specific aspects.

Therefore, only teamwork permits to meet in a holistic way the needs of the patients and their families.

The palliative care team is an example of constant integration between doctors and nurses specialised in palliative care who, by integrating services with general practitioners, create a palliative care network.

The relevance of the subject of "pain", its daily presence in nursing care and its psychological and physical impact on the patient, makes the ability to carry out an integrated pain assessment a primary ethical goal pertaining to nursing aptitudes.

Nurses are legally and ethically required to support patients within the healthcare system, ensuring that pain relief strategies are used and by promoting patient well-being and relief from suffering.

Article 23 of the Code of Ethics of San Marino Nursing Association reads as follows: "*Nurses undertake to prevent, monitor and alleviate pain and suffering of the person by performing all necessary treatments*".

In order to fulfill the duty of and to meet the need for care and treatment, the necessary means to quantify and evaluate, or rather to objectively identify pain and suffering, have been developed and created over time.

The specificity and possible effectiveness of nursing care depend upon the vicinity of the patient. Indeed, nurses are those who, more than any other person, *accompany* the patient through the experience of the disease, the treatment and any causes of pain and suffering.

In preventing and relieving pain, nurses are the closest to the patient. For this reason, they are the only ones who, through a change of attitude, can switch to listening, understanding and subsequently evaluating pain and suffering.

The pain that accompanies a disease, whether acute or chronic, fatal or non-fatal, is first of all the experience that patients have of their own pathology. It is therefore constituted by a primary sensory perception, unpleasant by definition (pain in physiological terms), and by the emotional component accompanying pain, which is deeply subjective and variable.

Therefore, nurses should not only transcribe pain as a vital parameter, but they must accept and understand it for what it is, i.e. an intimate and deep disorder experienced by the patient. Then, they must systematically apply a pain detection process primarily based, as much as possible, on prevention (not just of the symptom), but also on the anticipation of the desire and need for relief, before the request, and subsequently on:

- listening to patients without expressing any personal judgement and accepting their subjective perception (suffering), in order not to undermine diagnosis and treatment and to maintain the trust of the assisted person, who would otherwise feel underestimated and misunderstood;
- dialogue with the reference team. Nurses are responsible, together with other health care professionals, for negotiating those organizational changes that facilitate the improvement of pain management practices;
- administration of the prescribed treatment by the healthcare team's physician and response to efficacy.

Once the subjective perception has been considered, nurses will be able to implement appropriate multimodal assistance strategies, by also offering their fundamental personal contribution that consists in accepting, understanding and integrating suffering as a subjective perception of the patient, avoiding any personal judgements or initiatives.

This process (listening, dialogue, administration and response) shall in any case be respected for each category of patients, regardless of their age, ability or means.

In some situations, the privileged position of anticipation and "listening", vis-à-vis the assisted person, may facilitate dialogue aimed at finding complementary therapy solutions, which, combined with other treatments to improve pain control and reduce doses of analgesic drugs, may limit the incidence and severity of iatrogenic side effects.

In order to identify such therapeutic supports among unconventional techniques and/or medicines (for example, distraction techniques), nurses need to have specific knowledge in order to provide reliable information to the requesting patient: ignorance on this issue would leave patients alone with the risk of leading them to inadequate choices.

PROFESSIONAL ETHICS

In international scientific debate, the Review carried out in 2006 on the nurses' knowledge of and aptitude for pain assessment and management is of high interest. This analysis shows that the inadequacy in pain management is due, in many cases, to a lack of knowledge of this subject; limited training; lack of protocols for providing consistent treatments; and little aptitude of nurses in recognising and assessing pain as a clinical and care priority [5].

Therefore the National Bioethics Committee of Republic of San Marino (CSB) believes that nurse employment profiles and empathy in pain prevention and treatment should be more enhanced by means of awareness raising projects and continuous training.

In the area of prevention, it is ethically and professionally imperative that attention be paid to procedural pain (treatments, nursing, invasive procedures such as vascular access etc.). In such cases, in particular in home care treatment, it is not possible to assist only according to detailed and standardized protocols, but on the basis of the commitment, cooperation and experience of the whole team.

A multidisciplinary team and a multimodal intervention are based on shared methods, not just on protocols for medication administration.

According to the Committee, defining pain management merely as medication administration is very simplistic (and ineffective), because nurses shall also bring their personal and professional contribution in every analgesic treatment.

The Committee believes that pain prevention and treatment succeed when the basic principles of bioethics and professional ethics are respected.

- **Therapeutic or totality principle**

  This principle is at the basis of permissibility of a patient's treatment, provided that it is necessary for the safeguard of life itself and for the integrity of the person, understood in his psycho-physical totality.

  Closely linked to this principle is the proportionality of treatment, which is related to the knowledge of the concepts of appropriateness and futility.

  Therapeutic proportionality justifies the application or the continuation of treatment, even if risky and/or burdensome, in view of a greater benefit for the assisted person (and, vice versa, it justifies

[5] Mattacola P, Serio F, Mauro L, Fabriani L, Latina R., *Le conoscenze e le attitudini degli infermieri nella gestione del dolore: una revisione narrativa della letteratura*. Pain Nursing Magazine - Italian Online Journal, Vol. 3 - N. 4 2014: pp 138-154.

omission or suspension of treatment when the “burden” is too heavy compared to the benefits for the patient).

In these cases, the medical decision is also a value-based decision; therefore, the involvement of the patient or his substitutes is an indispensable duty.

Clinical appropriateness relates to the indication or implementation of health interventions in such a way that probable benefit outweighs risk.

From a clinical point of view, a treatment is clearly futile when it fails in strictly physiological terms; whereas in bioethical terms the concept of futility derives from a balance among the criteria of effectiveness, overall benefit and burden of the treatment.

A treatment cannot be performed when it is known that it will not produce any therapeutic outcome. Palliative care is an example both in chronic and end-of-life cases. Where the threshold of proportionality in the chronically ill is overcome, lacking reasonable expectations of recovery as a result of a therapy, the continuation of care favours palliative treatment as the most appropriate choice to treat an incurable patient.

- **Principle of beneficence**

  Acting according to the principle of beneficence means to take decisions aimed at obtaining benefit in the best interest of the patient.

  It applies both to the patient, reassured by the beneficence of the healthcare professional, and to the professional himself, who must be trained and supported.

  This can be achieved through specialist training, but above all through a program ensuring ongoing training and maintenance of the skills acquired. Such program should consider the whole psyche-soma of the healthcare professional under the supervision of and in cooperation with the team in which nursing is provided.

  In the context of pain and suffering treatment, a common violation of the principle of beneficence includes delays or omissions in the administration of painkillers, due to the fact that pain and suffering relief is not recognised as a clinical priority.

  In order to comply with this ethical principle, nurses must resort to all methods at their disposal to ensure that patients can, in any case, receive a treatment aimed at reducing pain in due time and in the manner which best suits their needs, regardless of the place and the time of care.

  In this context special attention shall be paid to treatments with poor scientific efficacy, but that can induce the so-called "placebo effect", which is very frequent in response to pain.

The ethical acceptability of such treatments should be assessed on a case-by-case basis, in relation to the risk-benefit ratio of each single treatment.

- **Principle of non-maleficence**

  It derives from the principle led down by Hippocrates "*primum non nocere*".

  Health professionals often rely on the principle of non-maleficence to refrain from administering a medicine (or an higher dosage of a medicine) that could bring relief to patients, for fear of side effects.

  However, in order to be applied, this principle should be balanced with that of beneficence, following a detailed analysis of the risk-benefit ratio.

  Nurses, in order to avoid infringing upon the principle of non-maleficence, must know and consider the side effects that can be associated with the experience of pain not properly treated, whether emotional (anxiety, self-harm) or physical (negative effects on the regulation of blood pressure, heart activity and endocrine system).

  Nurses, together with the team caring for a patient, shall also commit to finding alternatives to non-applicable analgesic treatments, following the principle according to which contraindications to a medicine should not be transformed into contraindications to relieving pain.

  For this reason it is important that nurses are adequately trained; they should also be protected, like the rest of the team, (also for the patient's safeguard) from work-related stress problems, such as occupational burnout, which can lead to negative behaviours toward patients and trigger organizational problems.

- **Principle of autonomy**

  On the basis of this principle, all individuals have the right to know, choose, request and reject a treatment that may be useful to alleviate their pain and to receive, therefore, detailed and comprehensible information to be able to make that choice in full consciousness.

  The patient has also the right "not to know" and informed consent should be intended as a dynamic and conscious process rather than a mere bureaucratic act. During this process, patients can change their mind and be informed on some aspects, or request further information concerning other aspects, thus gradually becoming aware of their conditions over time.

  All persons have the right to make decisions about their health, irrespective of the opinions and prejudices of third parties.

  The principle of autonomy is violated when healthcare professionals do not respect the right of each patient to choose how his or her pain should be treated.

This violation also includes, for example, failure to provide patients with comprehensive information on how much and how often they can receive analgesic treatment.

In the context of therapeutic protocols providing for the autonomy of the person in pain management and in order not to adversely affect the effectiveness of such management, healthcare professionals shall act as transparent and present mediators. They shall also develop integrated team communication, which must be homogeneous and the result of periodic meetings for cases entailing a multidisciplinary and multi-professional intervention.

Integrated team communication ensures that healthcare professionals achieve and maintain a balance between the duty to provide information to patients and their autonomy to know and not to know.

In this context, it is fundamental to clarify the meaning of the concepts of withdrawal of treatment, futile medical care and treatment abandonment, in particular in end-of-life situations.

Withdrawal of treatment must be understood as the suspension or interruption of those treatments that only result in a painful and useless prolongation of agony of the end-of-life patient, in the light of a risk-benefit ratio in which benefit is null and treatment is inappropriate since it is excessive.

The decision to withdraw treatment should not be considered euthanasia, since the death of the person, if occurring, is neither desired nor sought, but is an irreversible process.

Similarly, withdrawal of treatment should not be identified as treatment abandonment, which is instead a form of euthanasia, i.e. an action or omission which, in and of itself and by intention, causes death, with the purpose of eliminating all suffering.

Futile medical care must be understood as overtreatment compared to the goal of treating patients, for the risks it entails, for the documented ineffectiveness of the treatment and for its burden.

- **Principle of justice**

  According to the principle of justice, every patient must be guaranteed the necessary treatment, according to the parameters of appropriateness and proper allocation of available resources.

  We can consider for example an athlete who, even for a minor injury, may feel pain and suffering in a peculiar way due to the violent impairment, albeit temporary, of all his social and professional activities.

  Therefore, this example shows the importance of considering every individual as “weak” when providing relief from pain and suffering, without *a priori* adapting treatment and resources to predetermined standards.

Relief from pain and suffering is also recognized as a fundamental human right. As stated previously, it is achieved through teamwork in the context of a clinical and healthcare decision-making process based on which a higher share of resources is allocated to a patient having higher chances of healing or urgently needing to restore his physiological functions, compared to another patient, since (organisational and economic) health resources are not unlimited. In this context, in compliance with the principle of justice, nurses focus their attention on patients that the other members of the team cannot treat effectively in order to ensure comprehensive pain relief.

Such distribution of the various competences among the team members ensures that the therapeutic principle is respected for all patients, providing each of them with the most appropriate care.

CONCLUSIONS

The Committee recognises the fundamental value of nursing in pain treatment, by virtue of the privileged and close relationship that has always existed between patients and nurses.

Therefore, in the light of the observations made, the Committee believes that pain management nursing must be based on the following ethical requirements:

- recognition of the subjective and articulated component of pain in any individual patient in order to not violate the principle of justice;
- recognition of the attention to pain as a clinical and urgent priority in order to ensure compliance with the principle of beneficence;
- knowledge of complications related to insufficient pain treatment as a benchmark against which to measure the principle of non-maleficence;
- reliable, correct and comprehensible information to patients, acting as a support and guarantor of their freedom of therapeutic choice in order to ensure compliance with the principle of autonomy;
- the need to avoid the negative stigma of pain and suffering (on the contrary, it is appropriate to assist patients in terms of pain integration and resilience when pain cannot be completely controlled);
- In the particular context of palliative care and end-of-life nursing, the general therapeutic attitude is not focused on efforts to treat the disease, but on palliative care. Palliation is an admission of inability to overcome a disease and, at the same time, a declaration that the ill person will not be left alone. Consequently, attention should be given to reduce all forms of suffering affecting ill persons both physically and psychologically, where it is not possible to eliminate pain. It is important to recognize that in case of end-of-life patients the principles of beneficence and justice defend appropriate and intensive pain treatment more than the fear of side effects justifies a conservative approach. The objective is no longer to "heal", i.e. to cure a disease and to extend life expectancy, but rather to alleviate pain, that is to say to reduce any suffering that a person undergoes. Therefore, the lawfulness of end-of-life care is established by its very purpose, namely to alleviate suffering by refraining from any treatment directly aimed at accelerating the death of the patient.

RECOMMENDATIONS

The Committee, in awareness of the necessity to carry out an integrated assessment of pain and suffering through a multidisciplinary multi-modal approach, expresses the following recommendations:

- nurses must be an active part of a multidisciplinary team, knowing the different fields of intervention, as well the contribution in terms of diagnosis and treatment that each member of such a team is able to make for the treatment of patients;
- nurses, wherever they practice, have the responsibility to undergo training and to be continuously updated on the specific aspects related to pain treatment;
- it is necessary to ensure continuous support to nurses, even in a team, in order to prevent burnout;
- nurses should know and integrate, if possible and when required, non-pharmacological techniques for the control of pain and be able to inform patients about pain and suffering management to help them make informed and free therapeutic choices.

APPENDICES

THE NURSING PROFESSION IN REPUBLIC OF SAN MARINO

The profession of nursing in the Republic of San Marino took its first step in the 1940's when the profession was learned only by working in the field, from the practical experience of doctors, religious personnel and older nurses.

With the transformation of the learning activity in a more structured modern nursing school, the professional figure of the nurse, from the straight dependence of the physician, became more autonomous with specific duties in terms of patient care and integration in the health system. The nurse is now part of the health team with specific and independent duties.

The development of the nursing role and its education made it necessary to have codes and regulations for this important profession.

During the Second World War the hospital of San Marino treated a large number of patients; the nurses who worked in the hospital were recruited among unmarried people in good health, people from good families and in possession of a good reputation (referenced among persons of greater social importance of the time). The work ranged from cleaning, management of the kitchen and linen room up to the administration of medication to the sick.

During the following years the first nurses trained at the boarding school in Bologna, Italy arrived to the San Marino hospital. Thanks to these nurses, a new organization of work and a greater awareness of the identity and role of the nursing profession gradually began.

However it was only in 1981 when the whole nursing body aligned in a sole professional figure by an extraordinary retraining of the entire staff that was, up to that time, generic.

In the 1990's, finally supported by the existing nursing schools, an academic course was established. It conferred a degree and, as a result of the reform of the university of the year 2000, a three year degree course (followed by the closing of the old nursing schools) and a Bachelor of Science Degree (for the training of researchers, nursing directors and university professors).

In the same way, the fact that the so-called job description (a closed catalogue of duties assigned to nurses) was no longer compatible with a professional figure whose role had become more important. The nurse takes part in the process of care and assistance of the patient within a team, and assumes decisions as an expression of the professional vocation and also the consequent responsibilities.

This change, for the nursing professionals of the Republic of San Marino, has been definitely accomplished by the adoption of the so-called "role profile" that replaces the obsolete job descriptions,

and has projected the nurses towards the dimension – already acquired by their foreign colleagues – of practicing a free profession.

It was therefore inevitable that nurses who became professionals adopted their own Code of Ethics, which was carried out with the support and guidance of the National Bioethics Committee of Republic of San Marino and approved on May 15, 2017 [6].

Finally, it is hoped that soon it will be possible to establish a professional association to enforce compliance with these rules and binding on anyone who intends to practice nursing, and on the permanent formation of their members.

These elements are the essential and mandatory pillars for the enhancement of the professional itinerary aimed to ensure that nurses become professionals present at the side of the patient and ready to accompany him effectively in his encounter with the disease and supporting him in his battle.

REGULATION OF THE REPUBLIC OF SAN MARINO[7]

Decree May 5, 2005 n°70, *Regulation in the matter of authorization in the establishment and practice of public and private health care, social health, and social educational facilities* (Attachment 2.1.2).

Decree October 22, 2014 n°165. *Profiles of roles in the extended public sector.*

[6] The code may be found at the following website: http://www.sanita.sm/on-line/home/bioetica/comitato-sammarinese-di-bioetica/documenti-csb-italiano.html

[7] Regulation may be downloaded from the website of the "Consiglio Grande e Generale": http://www.consigliograndeegenerale.sm/on-line/home/archivio-leggi-decreti-and-regolamenti.html

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