A growing body of research has drawn attention to the hierarchical and bureaucratic nature of the hospital organizational environment in which nurses seek to resolve ethical problems related to patient care, whereas other studies have focused on the impact of nurses’ personal or professional qualities on those nurses’ ethical problem solving. This qualitative investigation sought to elucidate the extent to which nurses perceived their personal or professional qualities, as well as organizational characteristics, as influencing their ethical decision making. This investigator interviewed 10 registered nurses in 2 acute-care hospitals that were different in size, location, and type. A relational ethics lens assisted in the analysis of the data, emphasizing ways in which the nurses’ ethical problem solving was socially situated within a complex of relationships with others, including patients, families, physicians, and coworkers. Data analysis revealed key themes, including the nurses’ concern for patients, professional experience, layered relationships with others, interactions within the organization, and situational analysis of contexts and relationships. Subthemes included the nurses’ relationships with patients, physicians, patients’ families, and coworkers. This study revealed a range of ethical problems. Nurses saw their patients as their greatest concern; the nurses worked within a social context of multilayered and complex relationships within a hierarchical, bureaucratic organization with the desire to bring about the best outcomes for patients. The participants described ethical concerns related to the actions
or decisions of physicians, patients’ family members, and nurses’ coworkers. The nurses’ deliberation to resolve these ethical problems considered risks and benefits for patients, nurses, and others. The nurses seemed to carry out a contextual assessment, analyzing the presence of mutual respect, the extent of relational engagement, and the potential for opening relational space in order to work together with others to resolve the ethical problem for the patient’s best outcome. The nurses’ ethical actions were socially situated within this complex interpersonal context. This thesis discusses implications of these findings for nursing research, education, and practice.
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DEDICATION
I dedicate this work to my husband, Gerald Phillips, and to the memory of my parents, Helen and Kenneth Knutson.
CHAPTER 1: THE ORGANIZATIONAL CONTEXT OF NURSES’ ETHICAL PROBLEM SOLVING

The Study in Brief

This qualitative investigation sought to elucidate the extent to which nurses perceived their personal or professional qualities, as well as characteristics of their employing organizations, as influencing their ethical decision making. Ten registered nurses participated in interviews, responding to prompts. The nurses described their own qualities, their experiences, and the relationships in the organization related to the nurses’ ethical problem solving.

The results revealed that the nurses viewed the patients in their care as their primary concern and that the nurses worked within a multilayered social context to bring about the best outcome for the patients. The nurses identified a number of ethical problems related to the actions of others, primarily physicians, patients’ families, and the nurses’ coworkers. Key themes included the nurses’ professional experience, their layered relationships with others, interactions within the organization, and the nurses’ situational analysis of contexts and relationships. The nurses’ deliberations to resolve the ethical problems involved some analysis of risks and benefits for the patients, themselves, and others.

A relational lens provided assistance in the data analysis: The nurses’ contextual assessment involved consideration of the presence of mutual respect, the extent of relational engagement, and the potential for opening relational space as the nurses sought to work with others to bring about the best outcomes for the patients. The nurses’ ethical actions were situated within a complex and layered social context. This thesis discusses implications of these findings for nursing research, education, and practice.
Introduction

The very act of providing nursing care involves ethical choices; the moral values guiding nursing practice have been described as those related to care, compassion, and the respect for human dignity (Benner & Wrubel, 1989; Benner, Tanner, & Chesla, 1996; Fagermoen, 1997; Lutz, Elfrink, & Eddy, 1991). Health care restructuring in the 1990s, motivated by cost cutting and business efficiency values, has been interpreted as diminishing support by health care organizations for those guiding nursing values (Aiken, Clarke, & Sloane, 2000; Antrobus, 1997; Rodney & Varcoe, 2001); diminishing nurse job satisfaction and increasing nurse burnout (Aiken et al., 2001; Peter, Macfarlane, & O’Brien-Pallas, 2004); and increasing the risk of patient mortality (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Clarke, 2004). Within such a context, it is not surprising that research has identified nurses’ dissatisfaction with their ability to provide ethical care (Peter, Macfarlane, et al., 2004).

Evidence has shown that nurses are aware of their ethical responsibilities to patients (Cassidy, 1991; Chambliss, 1996); however, some researchers have found that the structure of the work environment can limit nurses’ ability to act on their ethical decisions (Adams & Bond, 2000; Olson, 1998; Redman & Fry, 2000). Since the late 1980s, compelling research has implicated work environment changes in nurses’ increasing concern over threats to their moral agency (Varcoe & Rodney, 2002; Yarling & McElmurray, 1986) and in nurses’ reports of increasing moral distress (Peter, Macfarlane, et al., 2004). The effects of restructuring, including reductions in nursing staff and resources, have caused some researchers to describe contemporary nursing workplaces as morally uninhabitable (Peter, Macfarlane, et al., 2004). Yet, in the face of
those substantial barriers, some nurses have responded to ethically problematic situations by acting rather than remaining passive (Peter, Macfarlane, et al., 2004); it is unclear how nurses’ personal and professional characteristics and those of the organization interact to influence nurses’ ethical problem solving.

Some researchers have depicted individual nurses as struggling to autonomously do what ought to be done within a structure that tends to constrain the nurses’ freedom to act (Falk Rafael, 1996; Yarling & McElmurray, 1986). Viewing nurses as autonomous and objective decision makers, previous researchers have evaluated nurses in terms of their ability to discern and carry out what ought to occur, notwithstanding organizational constraints to moral action (Benner et al., 1996; Davis & Aroskar, 1978; Davis, Aroskar, Lisachenko & Drought, 1997). However, other researchers have begun to cast light upon those very organizational constraints, describing limits that are exerted upon all health care providers’ ethical decision making within modern health care organizations (Chambliss, 1996).

Within nursing, managers and executives share the same ethical concerns as bedside nurses (Brosnan & Roper, 1997; R. W. Cooper, Frank, Hansen, & Gouty, 2004). Although little was known at the time about the circumstances surrounding health care executives’ general ethical decision making, Jurkiewicz (2000) documented reports by senior health care executives of widespread unethical behaviour. Of great concern was Jurkiewicz’s finding that the participating executives believed that they were unable to improve the ethical environment of the organizations that they headed. Not only have bedside nurses reported distress related to the environment in which they make ethical
choices, but it seems that nursing middle managers (Gaudine & Beaton, 2002) and hospital senior executives (Jurkiewicz, 2000) also have experienced ethical discomfort.

Recently, researchers have begun to recognize the importance of interpersonal interactions in ethical problem solving. Some have focused on the influence, in particular, of the power exerted by the organization or physicians as nurses attempt to resolve ethical problems related to patients’ care (Ceci, 2004a, 2004b). Others have discussed the importance of interpersonal relationships in resolving ethical problems; for example, Bergum (2004) described all interpersonal encounters experienced by nurses in their professional work as having an ethical component and believed that attending to the quality of interpersonal relationships not only between caregivers and patients but also among coworkers and others enhanced ethical care.

Notwithstanding all of these structural limits to nurses’ ethical action, evidence exists that many nurses do act to provide ethical care according to nursing’s caring values and are able to resist, challenge, and work effectively within and around the various constraints to their ethical choices (Peter, Lunardi, & Macfarlane, 2004). Research has not, however, clearly articulated how nurses recognize ethical problems in their clinical practice, how and when they choose to act in relation to those ethical problems, or the aids and hindrances to nurses as they act upon those ethical problems. Nor has previous research clarified how the qualities of nurses and those of the organizational context interact in the nurses’ ethical problem resolution. This study explored nurses’ ethical problem solving as perceived by the nurses themselves.
Study Questions

The research sought to gain nurses’ perceptions of the following questions:

1. What are the values expressed by the nurses?
2. What situations present ethical problems for nurses?
3. What is it that makes such situations problems?
4. How does the nurse act upon such problems?
5. What are the things that help the nurse in dealing with ethical problems?
6. What are the things that hinder the nurse in dealing with ethical problems?

Conceptual Framework

The following includes a description of the conceptual framework for this study, including key background context and perspectives from the nursing literature, as well as a discussion of how the study findings shaped the evolution of the conceptual framework. The following discussion presents each of these areas.

Key Background Context

The 1990s saw major changes in the work environments of nurses. In Canada, as in other countries, problems of work intensification, increasing patient acuity levels, and staffing shortages came to characterize nurses’ work. Some researchers began to report findings indicating that these factors created an environment in which nurses’ moral agency was increasingly constrained (Peter, Macfarlane, et al., 2004; Varcoe & Rodney, 2002). This researcher became interested in this area of study after reading the emerging research and other papers describing the increase in moral distress experienced by hospital and other nurses. This literature was consistent with the investigator’s own observations of nurses’ increasing frustration with their work contexts. As a nurse
educator, this researcher was concerned about these changes in the nursing work environment because they could only intensify the challenges facing newly educated nurses entering the profession.

Two areas of previous research were of particular importance in developing this investigation, namely, the research on nurses’ actual ethical beliefs, values, and behaviour, and the growing literature focusing on the role of the work environment on nurses’ ethical decisions and actions. The following section presents discussion of both.

**Nurses’ Ethical Beliefs and Behaviour**

Nursing practice acts and codes of ethics emphasize that nurses’ primary concern should be their patients (Canadian Nurses Association [CNA], 2008; College of Nurses of Ontario [CNO], 2009). A number of researchers have provided growing evidence that practicing nurses value patients as being the central focus of the nurses’ care and function from a perspective that emphasizes the patients’ best interests (Erlen & Sereika, 1997; Fry, Harvey, Hurley, & Foley, 2002; Lützen & Schreiber, 1998; Redman & Fry, 2000; Wurzbach, 1999). Most of these researchers had conducted qualitative investigations with small samples, sometimes including nursing students or non-RN staff as well as registered nurses. Both the investigator’s own previous observation and the growing body of nursing research supported the notion that nurses recognize the need to consider patients’ rights of choice in health care, reflecting a valuing of patient self-determination.

Although nursing ethics educational literature often has focused on describing decision-making models to help nurses find resolutions to their ethical problems, some evidence has suggested that the ethical problems facing nurses generally are not problems of discerning what to do. Rather, they are problems of finding ways to bring about
solutions that the nurses believe to be correct; the nurses’ problem is not what to do, but how to bring about that solution (Redman & Fry, 2000; Wurzbach, 1999). These research results have resonated with this author’s experience and observation of nurses’ struggles with ethical problems; these results have underlined the broadening of the focus from individual nurses’ thoughts, values, and actions to include possible aspects of the environmental context that could support or impede nurses’ resolutions of ethical problems.

Some researchers have provided evidence that nurses’ ethical actions also are mediated by professional development, explaining nurses’ variations in their adherence to ethical requirements set out in nurse practice acts and codes of ethics. Benner et al. (1996), in their study using the Dreyfuss skill acquisition model, found that ethical behaviour was deeply developmental and that not all of the experienced nurses in their sample became ethically expert. In a related study, Rubin (1996) described nurses in the sample who were experienced but morally less competent as restricting their focus to the patients’ physical condition, as reducing ethical concerns to legal problems, and as deferring decision making to others, when compared with expert nurses. These researchers collectively differentiated between “expert” and merely experienced nurses. Useful as these studies were in conceptualizing this study, they tended to elicit stories of nurses’ ethical effectiveness without discussing with those nurses other circumstances in which they decided not to act or decided to act less vigorously. It was my view that researchers should solicit examples of ethical action and inaction from ethically active nurses to better understand the interaction between nurses and the environmental context in ethical decision making.
In conceptually unrelated studies, other researchers have provided evidence of a range of behaviours that nurses might exhibit in response to ethical problems, including blaming others or the organization (Lützen & Schreiber, 1998); subordination of self (Sleutel, 2000); and powerlessness (Ahern & McDonald, 2002; C. Kelly, 1998; Rubin, 1996). Taken as a group, these studies have suggested that nurses vary in their ability and willingness to resolve ethical problems. However, these studies have not addressed the qualities of the individual nurses and how those qualities might influence the nurses’ ability or willingness to act in ethically challenging situations. Nor have any of these studies addressed the concept of risk or riskiness for nurses in explaining why and how some nurses, but not others, acted, nor have any of these studies discussed nurses who were ethically active in some circumstances and contexts, but not in others.

The results of the current study supported previous findings about nurses’ concern for patients’ rights, best interests, and well-being. In addition, it was clear that the nurses in the study engaged with their patients and others in resolving ethical problems and that their ethical problem solving was socially mediated. The nurses spoke of knowing their patients and seeking to know the patients’ wishes and concerns; as well, they worked with their patients, managers, coworkers, family members, and physicians to bring about the best outcomes for their patients. Faced with this evidence of a relational emphasis in the nurses’ ethical problem identification and resolution, this investigator sought relevant models of relational practice. This researcher again reviewed the ethics literature, including the work of Gadow (1999) and Bergum and Dossetor (2005), who used Gadow’s work in their more recent research; both provided the researcher with further assistance in conceptualizing this study.
Principle-based ethical approaches, which emphasize decision making by autonomous decision makers removed from the particulars of situations, continue to dominate the field of health care ethics. Some researchers have viewed as unrealistic the ideal of disinterested, autonomous ethical decision makers (Chambliss, 1996). Some critics also have pointed out that this view of health care ethics focuses on the autonomous rights of individuals and a legalistic emphasis, and have criticized its inadequacy for dealing with the complex reality of human relationships (Bergum & Dossetor, 2005). Although others have advocated an ethic of care (Gilligan, 1982) or virtue ethics (McIntyre, 1974), relational ethics has emerged as an approach to health care ethics that not only recognizes but also emphasizes the reality of human relationships and their importance in ethical decision making. This emerging conceptual framework constituted a very interesting addition to the framework for this study.

Gadow (1999) proposed that the modernist perspective reflected in rule-based ethics that she called objective detachment was built upon a much older historical approach that she called subjective immersion. Gadow asserted that the modern perspective of objective detachment is inadequate for the situations in which nurses find themselves. Proposing a “postmodern turn,” Gadow urged a move toward an approach that she called “intersubjective engagement” (p. 62), the hallmark of which is the relational narrative cocreated by the patient and nurse. Bergum and Dossetor (2005) developed a number of key constructs associated with relational ethics: environment, relational engagement, mutual respect, and embodiment. In this developing theory (Bergum, 2004), the ethical environment is made up of the people in it (i.e., the health care system is expressed through each human interaction which comprises it).
According to Bergum (2004), the environment is not “out there” (p. 489), but is the space between human beings as they relate to one another. Relational engagement refers to nurses and patients engaging in genuine attempts to understand the other person and their experience (Bergum, 2004); disengagement and interpersonal distance constitute the opposite of relational engagement. H. MacDonald (2007) described mutual respect as “the embracing of the values and ideas of others as a means to develop new understandings, rather than formulating judgements of these values and ideas” (p. 123); through mutual respect, individuals with different views and perspectives are ensured equality. Finally, Bergum viewed embodiment within relational ethics as “healing the split between mind and body . . . so that scientific knowledge and human compassion are given equal weight” (p. 492). According to relational ethics, people are called to be part of the relationships of the moment, engaging with one another in creating relational space in which to reflect on and consider ethical issues or concerns (Bergum, 2004; Bergum & Dossetor, 2005; H. MacDonald, 2007).

Bergum and Dossetor (2005), in their discussion of relational ethics, spoke of “relational space” (p. xviii) as the space within which ethical engagement could occur. Their research on relational ethics revealed specific concepts, namely, mutual respect, engagement, embodiment, and ethical environment, that support ethical problem solving. They described a relational process in which health care providers deliberately engage with others, care recipients and other care providers, with mutual respect in seeking to resolve ethical problems. They noted the role of embodiment in reuniting “thinking and feeling, doing and being” (p. 147), as well as the importance in relational ethics of creating (or “being”) an environment for reflection (p. 165) with the result of bringing to
light the complexity of ethical choices and possibilities. Bergum and Dossetor saw the environment as being made up of the individuals involved; by presenting this concept, they challenged individual rights as the primary focus of ethics, as it is in principle-based ethical approaches.

The nursing literature has been replete with enumeration of the challenges that nurses face in resolving ethical problems related to the care of their patients. What this literature seemed to seek in many of these discussions was a more effective relational space for ethical problem solving. This relational space would allow those involved to come together with respect for one another’s position and engage with one another within the relational space that they are able to create, becoming a more supportive environment for ethical choice and resolution. The stories related by the nurses in this study also seemed to describe a search for a relational ethic.

Hospital nurses function within organizations characterized by hierarchical distributions of power and authority, with administrators and physicians among those with more power and authority than nurses (Chambliss, 1996). Chambliss carried out an extensive ethnographic study involving hours of nonparticipant observation. His results suggested that ethical problems have arisen in hospitals because of the power conflicts between occupational groups and their representatives; mislabelling of intergroup conflicts as ethical problems; differences among the moral or ethical agendas of various occupational groups; increased intergroup conflict resulting from the increased power of groups such as nursing; and new and changing issues, such as HIV (Chambliss, 1996). That researcher’s work helped to unravel some of the complexity of the hospital context and challenged a commonly held depiction of ethical decision makers in principle-based
models as objective, dispassionate, and uninvolved; Chambliss asserted that ethical modern hospitals rarely leave ethical decision making at the individual level.

Some researchers have suggested that an aspect of the hierarchical nature of hospitals involves privileging the knowledge and/or speech of some groups while diminishing that of other groups (Ceci, 2004a, 2004b). Ceci (2004b) used the work of Foucault to analyze events surrounding the 1994 deaths at a Winnipeg hospital of 12 children. She described how the alignment of “truth” discourses with power relationships in the hospital produced conditions of privileged speech for doctors and medical groups, who dismissed nursing observations, analyses, and advice as irrelevant. Subsequent to the silencing of nurses, many months were to pass, and more children were to die before action occurred. A subsequent inquest supported the perspectives of the nurses; Judge Sinclair drew specific attention to the cost in compromised patient care of positioning nursing and nurses in subordinate positions without the means to influence outcomes (Ceci, 2004b).

Ceci’s (2004b) analysis of a particular case of nurse whistle blowing used Foucault’s ideas of power to explain the social and organizational acceptance and support for nurses’ subordination to physicians, supported by society’s willingness to believe physicians’ knowledge to be more credible because of their higher social position. This social construction of knowledge attributing greater knowledge to those in higher social positions was shared by society, hospitals, and physicians, and created a circumstance in which nurses’ views, which conflicted with those of the physicians, were discounted, ignored, viewed with hostility, or subjected to ridicule within the nurses’ workplace.
Ceci pointed out that specific ideas presented as facts and produced to support particular perspectives could take on the aura of truth; in effect, the hospital social structure could confer privilege on particular perspectives such as those of physicians, with the effect that other facts, other aspects of truth, remain unrecognized.

The research has demonstrated how unresolved conflicts between nurses and physicians over approaches to care can cause patient care to suffer (Redman & Fry, 2000). Ceci (2004b) and Redman and Fry (2000) alluded to the riskiness for nurses of challenging physicians, even when the life of the patient was in jeopardy. The findings of the current study support the finding that the power differential between nurses and physicians continues to be pervasive and interferes with nurses’ ethical problem solving; physician behaviour is at times a source of nurses’ ethical problems.

The power differential between physicians and nurses is historical in nature; legislation and licensing regulations provide social and legal structure for it; and social expectations of the relationship between physicians and nurses, and of physician and nurse interaction, reflect it. These legal and cultural norms related to the two occupations manifest in the hierarchical nature of hospital workplaces, which reinforce them in multiple ways (Chambliss, 1996). The nursing workplace involves a fundamental power differential between nurses and the physicians with whom they share responsibility for patients, as has been described previous studies (Lützen & Schreiber, 1998; Schroeter, 1999; van der Arend & van den Hurk, 1999; Varcoe et al., 2004) and in the current investigation. This power differential manifests each time nurses have differed with physicians about patients’ best interests (Redman & Fry, 2000); each time nurses believe that physicians have violated patients’ right to choose (Redman & Fry, 2000; Sleutel,
2000), and each time nurses have expressed concerns about physicians’ competence or clinical decision making related to patients (Enes & de Vries, 2004; Redman & Fry, 2000; Varcoe et al., 2004).

Although efforts are underway to curb the abuse of physician power displayed in abusive and disruptive behaviours, it is the perspective of this study that there continue to be significant risks for nurses who challenge physicians’ power. Bergum and Dossetor’s (2005) developing theory of relational ethics could be useful in discerning ways in which ethical conflicts constitute a failure of relational engagement between nurses and physicians, and ways in which mutual respect or its absence could play a role in such conflicts.

Nurses have described their efforts to resolve ethical problems related to physician behaviour as involving substantial risk and vulnerability for nurses within the workplace (Ahern & McDonald, 2002; Ceci, 2004a), and much of this risk had to do with the view, shared by others within the organization, that physicians’ knowledge is automatically superior to that of nurses. The result for nurses working to resolve ethical problems involving patients may be to experience opposition not only from the powerful physicians but also from others within the organization at various levels of power and familiarity for nurses.

For decades, researchers have commented on the numerous competing obligations that nurses face when trying to resolve ethical problems in their practice (Smith & Davis, 1980; Storch, Rodney, & Starzomski, 2004). Researchers have provided some evidence that nurses experience conflict between their professional obligations to their patients and their obligations to their employers (Peter, Macfarlane, et al., 2004; Varcoe & Rodney,
2002) or to physicians (Sleutel, 2000). Expectations of nurses held by others for nurses to be efficient employees and effective members of the health care team may create for nurses a conflict between these other obligations and their primary obligation to patients. Such conflicting obligations may lead directly to ethical problems for nurses. Previous studies have not clearly addressed conflicts for nurses between obligations to patients and patients’ families or between obligations to patients and coworkers. Nurses in the current study described these conflicts as involving their concern for patients and others (i.e., family members, coworkers, and physicians), with their primary focus being patients. In analyzing these findings, a relational ethics perspective, including concepts of relational engagement, mutual respect, ethical environment, and embodiment, was useful in considering the multiple and layered relationships within which nurses attempt to resolve ethical problems.

A number of researchers have discussed the role of nurses within the hospital setting, depicting nurses as disempowered and prevented from carrying out the professional obligations required by nursing’s licensing bodies (Chambliss, 1996; Peter, Macfarlane, et al., 2004; Varcoe & Rodney, 2002). Hospitals are organizations that can call upon (a) legislation such as practice acts; (b) lines of authority; (c) policies and procedures; (d) norms of good employees (compliant, loyal, etc.); and (e) organizational culture to reduce the power available to nurses. It is this researcher’s perspective that nurses charged with responsibility for the well-being of patients often experience barriers in their attempts to direct human and other resources, including medical care, to the patients. Furthermore, individual nurses are in a poor position to challenge decisions made at a level above that of nurse managers because nurses usually do not have access
to decision makers above that level and others may view very negatively nurses who intervene at a level above that of nurse managers.

In most hospitals policies, are developed without input from staff nurses, with the result that such policies may have unforeseen impacts at the bedside and may constrain nurses from acting. Norms of the “good employee” (e.g., loyal, compliant, reliable, etc.) may have an impact on nurses’ willingness to challenge organizational, managerial, medical and other decisions, rendering “risky” behaviours that violate the ideals of good employees. Annual performance appraisals often include indicators that reinforce norms of quiet acquiescence and compliance, focusing on the employees’ completion of individual work and maintenance of harmony; again, nurses’ acts of resistance may be viewed by others as risky because they may result in negative evaluations. In the current study, the concept of risk and riskiness was important in evaluating possible actions by the nurse focused on resolving ethical problems.

Organizational culture, a less explicit variable, often develops through people’s observation of other persons’ experiences, including rewards and sanctions. It may be somewhat amorphous and therefore ambiguous, leaving individual nurses uncertain of the degree of risk involved in any behavioural options. The organizational culture also may be somewhat variable, introducing further ambiguity because of the changeability of outcomes for nurses from one interaction to another and from one set of circumstances to another. Nurses evaluating possible outcomes of various options in resolving ethical problems may have difficulty evaluating the risks inherent in particular alternatives. The organizational culture also may involve a tolerance of (or silence in relation to) negative or even abusive behaviour toward nurses by patients, families, physicians, coworkers,
and/or others, implying that these behaviours are acceptable and that the nurse employees are expected to tolerate them; this ultimately creates further risks for nurses associated with resisting or confronting such behaviours. In these ways, the organization may contribute directly to the ethical problems experienced by nurses (Yarling & McElmurray, 1986).

The interaction of characteristics of individual organizations and individual nurses constitutes an area that has not yet received specific attention, and it was an important area of investigation in this study. The finding that nurses view the organization primarily as the individual nursing unit and the interpersonal interactions within that unit led to a reconsideration of the study’s conceptual framework, refocusing on the relational aspects of the unit environment rather than the interactions of nurses with the organization as an entity.

During the 1990s, nurses experienced increasing pressure on their time brought about by practices that emphasized efficiency by measuring nursing tasks and planning patient care on the basis of numerical measures of nursing workload, indices that failed to account for all aspects of nurses’ daily effort on behalf of patients (Rodney & Varcoe, 2001; Varcoe & Rodney, 2002). The research that Varcoe and Rodney described has revealed that such management technologies have had the effect of reducing the focus of patient care to physiological aspects of medically diagnosed problems, with the intention of increasing efficiency and reducing expense; one observed result was that the nurses internalized these “efficiency” values and rewarded or sanctioned one another according to management efficiency goals. Their results have described how time to discuss or plan care has become rare and how nurses are being forced to donate time to the organization
by staying after the end of their shifts, but not claiming overtime. These researchers implicated the ideology of resource scarcity and the emphasis on corporate efficiency goals rather than on patient care goals in decreasing nurses’ moral agency, leading to moral distress.

The work of researchers such as Rodney and Varcoe (2001) informed the initial conceptual framework for this study, that is, emerging evidence of nurses’ increasing ethical and moral distress coincided with cuts to nursing staff and work intensification, on the heels of casualization of nursing employment. These factors have undermined nurses’ attempts to resolve ethical problems, pointing to the organization as an entity as being problematic for nurses. However, although a few examples implicating organizational policy in nurses’ ethical problems arose in this study, most of the findings focused on interpersonal relationships at the unit level. Varcoe et al. (2004) presented further evidence that nurses’ moral identities are “dialogical, narrative, relational and contextual” (p. 324); the evidence in the current investigation of an interpersonal emphasis in nurses’ moral deliberation supports those findings. It also supports the conceptual refocusing on relational concepts such as relational engagement, mutual respect, embodiment, and ethical environment in considering the findings of the study.

The current study focused on the beliefs, values, and behaviours of nurses that might have relevance to their sensitivity to, consideration of, and attempts to resolve ethical problems that occur in caring for patients. The conceptual framework for this study originally conceptualized the qualities of nurses as including personal and professional attributes: personal qualities might include family experiences, important aspects of the person’s development, or religious beliefs and values, whereas professional
attributes such as professional education, clinical nursing experience, key nursing values, and confidence are important factors. Professional knowledge of the nursing unit, the workplace, and others within those settings also could be important aspects of individual nurses that could influence ethical problem solving within a complex relational context.

The findings of this study support previous research that patients and the well-being of patients constitute a key concern of nurses. However, the findings also indicate that these nurses showed concern for others, including patients’ families, physicians, and the nurse’s coworkers. They also described their ethical problem solving as being socially situated, involving their relationships with others. Thus, relational engagement was a key concept in this study.

Likewise, nurses experienced ethical problems when others were unavailable or resistant to discussing ethical concerns with patients, nurses, or others. From the nurses’ perspectives, other people (physicians, family members, coworkers) were disengaged from the patients’ needs, rights, or concerns; this could lead to ethical problems for nurses. The conceptual framework depicted the underlying reason for the disengagement as disrespect for the other person, whether patient or nurse. These relational problems compounded and sometimes actually created ethical problems for the nurses.

Although this study was not designed using a relational ethics conceptual framework, it was valuable to consider the findings using a relational ethics lens. The nurses in this study discussed their relationships with patients explicitly and implicitly within their narratives about ethical problems that they were able to resolve as well as those that they found impossible to solve. The nurse participants most often described the
ethical problems in terms of broader relationships with others in the patient care setting, including relationships with patients, managers, coworkers, families, and physicians.

The types of ethical problems the nurses in this study identified included those that involved actions or decisions of patients, physicians, patients’ families, and the nurses’ coworkers. The nurses often considered the decisions of families in relation to patients and physicians, as well as the nurses themselves. Within this complex of relationships, the concepts of environment, relational engagement, mutual respect, relational space, and embodiment can be useful in considering the ways in which these relationships interrelate in ethically problematic situations. Likewise, the nurses described ethical problems related to coworkers’ behaviour that they witnessed, behaviour that was problematic often because the nurses believed that patients’ rights, best interests, or safety were threatened by those witnessed actions. A relational ethics lens can help to reveal issues associated with nurses’ relationships with coworkers and how these play out in the hospital environment.

Summary of Conceptual Framework

The nurses’ aforementioned multiple relational considerations come into play during the nurses’ identification of ethical problems and attempts to resolve them. The patients’ well-being is clearly paramount, but the other relationships and interpersonal considerations also come into play. Nurses’ clinical experience and knowledge are important to recognizing ethical problems, and they are relevant to nurses’ consideration of alternatives. Not only clinically experienced but also concerned about their patients, nurses engage with the people involved, sometimes opening and using relational space for ethical problem solving. Mutually respectful relationships can promote dialogue and
the discussion of alternatives, providing support to nurses in seeing the ethical problems resolved. Relationships, on the other hand, that are disrespectful toward patients, nurses, or others create barriers to ethical problem resolution. This type of ethical environment, created on a moment-to-moment basis, involves mutually respectful engagement with others to resolve ethical problems.

The concept of risk is associated with the types of relationships that exist at the time ethical problems emerge, and the level of mutual respect among those involved. Without mutual respect and positive relationships, ethical engagement by nurses could result in negative responses from others. Nurses are required to consider the relative risks of inaction or of possible actions. Problems related to the care or situations of patients involving or observed by nurses may involve an array of others. A relational ethics approach is helpful to consider the complex and varied relationships within which nurses attempt to bring about the best outcomes for patients by focusing attention on specific possibilities for the nurses and others.

The operationalization of this conceptual framework involves seeking specific evidence in the interview data. Evidence from the study participants, consistent with this conceptual framework, included the social and relational dynamics underlying those ethical problems, including nurses’ and others’ engagement. It also included the relational aspects of nurses’ reflection on, or consideration of, alternatives in working through ethical problems; the relational context within which nurses sought to resolve these problems and to create relational space; and evidence of tensions and/or conflicts arising from multiple social obligations. An example of the latter involved conflicts
between obligations to patients and obligations to physicians, families, coworkers, or employers.

It is clear that the circumstances surrounding nurses’ ethical problem solving are much more complicated and varied than had been thought in the past. This study resulted in the participants describing their consideration of multiple relationships at the same time as they described how they decided whether to act and how in resolving ethical problems. The study provided evidence of how nurses deal with these numerous relationships in relation to one another in ethically problematic situations.

Organization of the Thesis

The following chapters of this thesis are in the following order. Chapter 2 presents research literature relevant to the study, and chapter 3 outlines the methodology used in the investigation. The findings are presented in chapters 4 to 6. The discussion of the findings occurs in chapter 7 and highlights the important results presented in the preceding three chapters and considers them in light of the emerging relational ethics theory. Finally, chapter 8 provides a summary and a conclusion.
CHAPTER 2: REVIEW OF THE LITERATURE

In recent decades, the field of nursing ethics has been the focus of significant attention, particularly in relation to the interplay between the traditional caring values of nursing versus the values reflected in the nursing workplace, and the choices available to the nurses in that workplace. Emerging literature on the impact of the organization on nurses’ moral agency (Rodney & Varcoe, 2001) drew this investigator’s attention to the issue of nurses’ moral problem solving and to the impact of the organization on the nurse’s ethical choices. Driven by a concern about how to educate nursing students for the increasingly challenging nursing work environment in which they will eventually practice, this researcher wished to explore and review literature on the ways in which characteristics of that work environment interacted with the nurses’ personal qualities to influence their ethical problem solving.

The following discussion leads the reader through a review of the literature that informed the conceptual framework and methodology for this study. It presents a brief history of nursing ethics, followed by a discussion of nurses’ moral development, the nurses’ concern for patients, the nurses’ awareness of ethical problems, the ethical problems identified by nurses, and ethical action. A discussion follows of the support for and barriers to nurses’ ethical problem solving, including a review of organizational changes in the 1990s and their impact on ethically active nurses. The discussion concludes with a summary of the relevant literature.

Nursing Ethics

The following discussion provides a brief history of nursing ethics, including particularly relevant developments in recent decades. Initially “more concerned with
etiquette than with ethics” (Fowler, 1997, p. 19) and with the moral virtues of the good nurses, nursing ethics has consistently focused on “right action” (Fowler, 1997, p. 19). Lamb (2004) pointed out the value placed on Christian, humanitarian, and service ideals that nursing emphasized in the early 1900s. The 20th-century interest in professional codes of ethics augmented an emphasis on personal values with an expression of the professional group’s key values (Davis et al., 1997).

Developments arising out of medical ethics have dominated health care ethics, particularly the field of bioethics, which arose in the 1970s (Storch, 2004). Although the principle-based approaches of bioethics provided a valuable response to developments in medicine, including transplantation and life-prolonging technologies, the focus on individual relationships without consideration for broader relational concerns drew increasing criticism (Bergum & Dossetor, 2005; Storch, 2004). Support for ethics theories has varied from principle-based ethics and has included virtue ethics, care-based ethics, feminist approaches, communitarianism, and case-based ethics in broadening perspectives on health care ethics (Bergum & Dossetor, 2005). Some of these approaches have emphasized broader relationships as providing a context for ethical problem solving. The following discussion describes the key developments in nursing ethics over the past several decades.

From the 1960s to the 1980s, debate around health care ethics broadened from the limited field of medical ethics to the broader social discussion of bioethical dilemmas. Davis and Aroskar’s (1978) text reflected a turn in nursing away from a nursing ethic of institutional allegiance and a move toward applying formal ethical theory and objective ethical principles, reflecting an ideal of objective autonomous practitioners deliberating
on ethical principles in resolving ethical problems. Virtue ethics, out of favour during much of that time, has more recently attracted the attention of nursing ethics researchers and theorists (Davis et al., 1997).

In the late 1980s, nurse theorists began to link nurses’ lack of professional autonomy and the inability to bring about ethically positive results for patients (Liaschenko, 1993; Yarling & McElmurray, 1986), arguing that the organizational context precluded nurses’ autonomy to be ethical. Jameton (1984) theorized that organizational constraints prevented nurses from acting ethically, with the result that nurses, knowing what should happen but being unable to bring about that outcome for the patient, experienced moral distress.

Nurses’ Moral Development

In this section, the discussion focuses on the theories and research related to nurses’ moral development. It commences with discussion of the work of developmental psychologists Kohlberg and Gilligan through a brief presentation of research related to nurses’ use of principle-based versus caring ethics and then to evidence of professional skill acquisition as an explanation of nurses’ ethical development.

Kohlberg and Gilligan

There has been interest in nurses’ moral development for many decades. Much of the work in the 1970s and 1980s focused on Kohlberg’s (1978) theory of moral development, based upon a justice (i.e., rule-based) ethics orientation. Four cognitive processes have been hypothesized as being involved in moral behaviour: moral sensitivity to interpret the situation, moral judgement to identify the ideal course of moral action, moral motivation to choose among possible valued outcomes, and moral character
to persevere in implementing the intended action (Rest, 1983). However, the research underlying these hypotheses did not occur in a nursing clinical setting. A number of other studies based upon Kohlberg’s theory in the 1980s focused on nurses’ moral development and its relevance to ethical decision making; these studies yielded few clear results about the origins or processes involved in nurses’ ethical decision making (Lutz et al., 1991; Silva & Sorrell, 1991).

Caring ethics began to develop in the 1980s, as a challenge to the justice-based models such as that of Kohlberg (1978). Gilligan’s (1982) challenge to Kohlberg’s assertion of women’s moral limitations won immediate adherents within nursing, a female-dominated field. In contrast to the emphasis on rational objectivity and individuality of Kantian principle-based ethical theory that Kohlberg emphasized, a feminist ethical development model described women’s ethical decision making as relational and interactive, maturing to a stage in which care is emphasized as a way of resolving ethical conflicts, as opposed to a selection among conflicting rights and duties (Gilligan, 1982). In contrast to the emphasis of principle- or rule-based ethics on independence and autonomy, Gilligan’s caring feminist ethics focused on human connection and relatedness. Finally, rather than emphasizing the logical application of universal ethical rules, Gilligan’s conception of moral decision making focused on context and relationships.

**Research on Principle-Based and Caring Ethics in Nursing**

The notion of a gender difference in how people conceive of ethical problems and solutions has been the basis of research related to gendered workers such as nurses (predominantly female) and physicians (predominantly male), resulting in mixed findings
related to this gender hypothesis over time. Although some studies in the early 1990s showed evidence of a caring/justice divide between nursing and medicine (M. C. Cooper, 1991; Lindseth, Marhaug, Norberg, & Uden, 1994; Uden, Norberg, Lindseth, & Marhaug, 1992), more recent studies have failed to reveal that hypothesized difference (Holm et al., 1996; Kuhse, Singer, Rickard, Cannold, & van Dyk, 1997). Grundstein-Amado (1993) suggested that nurses and physicians might have difficulty identifying a specific ethical dilemma clearly; however, that researcher interpreted findings related to ethical reasoning specifically within a principle-based framework. A more recent qualitative study of physicians’ ethical deliberations showed an emphasis on avoidance of conflict, recruitment of assistance, protection of physicians’ conscience and reputation, and protection of the group involved in the ethical decision as goals in ethical decision making, areas of emphasis that sometimes have supported and sometimes have competed with patients’ goals (Hurst, Hull, DuVal, & Danis, 2005). Research results have not clearly supported the notion of nurses’ adherence to Gilligan’s caring approach or physicians’ adherence to Kohlberg’s justice-oriented principle-based approach in ethical decision making. It is not possible to conclude that a gender difference exists in the ethical decision making of nurses and physicians.

Pierce (1997) suggested that ethical decision making could involve two levels of moral reasoning, namely, cognitive and philosophical, and that nurses may tend to reflect a person-dominated philosophical ethic, whereas physicians tend to reflect a science-dominated ethic. The model of the moral dynamic developed by Pierce showed concentric circles representing (from surface to core): ethical reasoning cognitive functions; values, worldview and view of self; empathy and compassion; and at the core,
emotions and virtues. The research based upon that model also revealed an alternative philosophy in a small subgroup of experienced older physicians, who seemed to hold person and science orientations in equilibrium (Pierce, 1997). It was not clear from this research whether older, more experienced nurses also might hold both of these perspectives in balance.

The perceived inadequacies of principle-based ethics have contributed to an interest in caring ethics and a renewed interest in virtue ethics. Although some researchers have hypothesized caring as a sensitizing preliminary to principle-based ethical deliberation (Kuhse et al., 1997), others have seen it as the single defining feature of nursing and nursing ethics (Benner, 1997; Watson, 1988). Still others have viewed caring as a virtue (Allmark, 1998; van Hooft, 1999). Although some have engaged in theoretical dissection of differences between caring ethics and caring as a virtue (Allmark, 1998; Benner, 1997) and debated caring ethics versus virtue theory versus principle-based ethical decision making (Gardiner, 2003; Jansen, 2000; Svenaeus, 2003), others have attempted to theorize caring as the overarching virtue that gives moral meaning to nursing action (van Hooft, 1999).

Caring ethics has had critics of its own. Notably, the particularistic nature of caring can seem to imply a preference for one patient over another, violating nursing values of caring for all patients fairly. In addition, there have been critiques of an ethic based solely upon caring in its various manifestations as a trap for nurses as women (Falk Rafael, 1996; Paley, 2002). Challenges to caring ethics as the sole basis for nursing ethics have been published (Crigger, 1997; Hoopfer, 1998; Pooler, 1999; Taylor, 1997). Nurse authors have noted nurses’ use of caring and justice orientations (Cady, 1991; Lipp,
lending support to the development of an ethic combining the equity principle of principle-based ethics and contextual, needs-based aspects of caring-oriented ethics (Botes, 2000; de Casterle, Roelens, & Gastmans, 1998; Olsen, 1993).

A few researchers have discussed the use of both principle-based and caring ethics approaches. For example, one study found nurses to use principle-based ethics at the beginning of their relationships with the patients, but as the relationships deepened, the nurses’ ability to view the situations from the patient’s perspectives increased (Krishnasamy, 1999). Nurses and physicians have been found to use deontological and teleological arguments in resolving dilemmas; however, those same practitioners also have described themselves as using other approaches, such as the notion of the relationship as an end in itself (Holm et al., 1996). Researchers have found a paucity of consequentialist argument used by the participants in their studies (Holm et al.); in fact, research in nursing has failed to show clearly that nurses consistently use any one of principle-based, consequentialist, caring, or virtue-based approaches to ethical reasoning.

Professional Skill Acquisition and Moral Development in Nursing

Professional development has received attention as an attribute of ethically active nurses, focusing on the role of clinical experience as an aid to the nurse in developing ethical decision-making ability (Åström, Furåker, & Norberg, 1995). Some investigators have used the Dreyfuss skill acquisition model (Dreyfus & Dreyfus, 2009) to consider the development of nursing judgment in nurses’ clinical expertise. The model, developed through research on skill acquisition in a number of health and nonhealth disciplines, has been used as the framework for a number of nursing studies since the early 1980s, exploring the clinical decision making and judgement of nurses at five stages of
Several studies have described the pivotal role of clinical experience in the development of nursing expertise. An important study by Benner et al. (1996) focused on intensive care nurses’ progress toward professional expertise and described the development of moral agency at each stage of expertise development. The study was theoretically based upon nursing as a caring practice, in which both virtue and caring ethics formed a moral base, and in which relational ethics would dictate that nurses strive not only to do the right thing but also to do so within a positive relationship with the other person. The study also built on Benner’s (1984) seminal study of nurses’ acquisition of clinical expertise, in which the Dreyfuss skill acquisition model supported the finding that nurses develop from novice, through advanced beginner, competent and then proficient nurse, to expert in their evolution as clinical practitioners. This study by Benner et al. revealed that beginning nurses would “delegate up” to others with more experience and that advanced beginners tended to have faith in the health care team’s ability to reduce suffering and limit mortality.

According to Benner et al. (1996), competent nurses are able to assess other caregivers’ competence and identify ethical problems in end-of-life situations as organizational lapses resulting in unsafe practices, whereas proficient nurses elaborate a sense of clinical agency based upon an ability to judge what is important, recognize shifting relevance, and take in the global situation. Finally, Benner et al. found that expert nurses grasp clinical situations, carry out response-based nursing practices, recognize the
unexpected, see the big picture, and see future possibilities (Benner et al. indicated that
expert moral agency requires

(1) Excellent moral sensibilities (a vision and commitment to good clinical and
caring practices); (2) perceptual acuity (the ability to identify salient moral issues
in particular situations); (3) embodied know-how; (4) skilful engagement and
respectful relationships with patients, families, and coworkers; and (5) the ability
to respond to the situation in a timely fashion. (p. 160)

Research conducted by Benner (1984) and Benner et al. (1996) has provided very
important information on the development of nursing skill. However, recent critiques
have called into question the tightly constructed methodology introduced by Benner and
copied extensively that focuses on nurses’ recollections of positive examples from their
practice, which some researchers have asserted have led to the production of certain (i.e.,
narrow) types of individual narratives while failing to represent the full range of nursing
practice (Nelson & McGillon, 2004). Notwithstanding such criticism, the work of Benner
et al. has elucidated at least some aspects of nurses’ moral development.

There is some evidence, based upon skill-acquisition theory, that nurses
possessing proficiency or expertise in clinical practice are more likely to possess
extensive skills in ethical problem solving, be more self-aware and guided by moral
emotions in evaluating their ethical choices, and be willing to violate orders in the best
interests of the patients (Åström et al., 1995). Åström et al. (1995) found nonproficient
nurses to be uncertain, hesitant, and self-conscious, and to perceive themselves as being
powerless to prevent patients’ negative outcomes. This finding suggests that becoming
ethically active nurses is a developmental process.

Studies have explored the phenomenon of ethically experienced, but not expert,
nurses versus clinically and ethically expert nurses. Rubin (1996) found some nurses not
to be expert nurses, despite their considerable experience. Those experienced, but not expert, nurses exhibited a constellation of characteristics. They lacked the ability of expert nurses to make qualitative, meaningful distinctions among specific patients and clinical phenomena; they restricted their goals to improvements in patients’ physical conditions; they tended to reduce ethical decisions to judgements about the legality of particular alternatives; and they completely deferred responsibility for clinical decisions about their patients. According to Rubin, the moral confusion evident in these nurses related not to their lack of clinical experience but rather to their lack of clinical expertise. Rubin pointed out that the nurses in the experienced, but not expert, group were unwilling to take responsibility for their actions and for the resulting good or bad outcomes, and were unable to act with authority to bring about positive outcomes.

A few other researchers have investigated the seeming dichotomy of ethically active versus nonactive experienced nurses. Some nurses have been found to have relied on peers to form opinions, scoring the highest on norm-based ethical decision making on the Defining Issues Test (DIT), whereas others did not rely on peers but formed opinions autonomously, scoring the highest on principled-based ethical decision making on the DIT (Cretilli, 1994). A qualitative investigation resulted in suggestions that some nurses were described as accommodating reasoners (i.e., reconciling ethical decision making to conform to the peer group) and others were described as sovereign reasoners (i.e., reconciling ethical decision making to conform to self-held values regardless of the peer group’s values), again creating a dichotomy of ethically active and nonactive nurses (Omery, 1985). Both of these studies drew attention to the possible influence of the work context in nurses’ ethical reasoning. The work of Cretilli, Omery, and Rubin (1996),
when taken together, suggests that the experienced nurses in the studies may have reflected at least two approaches to clinical ethical decision making. One group exhibited a need to affiliate with, and depend on, others in the work group and to defer to the group’s norms, whereas the other group showed an ability and willingness to make ethical decisions independently, without regard for group norms. Although the methodology of these studies did not provide for an exploration of whether ethically active or “sovereign reasoners” also experienced instances in which they decided not to act to resolve ethical problems, the results of these studies may not provide a complete picture of nurses’ characteristics.

None of the cited studies has investigated how personal values and organizational context might interact to influence nurses’ ethical decision making. It is possible that the morally dependent or inactive nurses in the studies already cited may have reflected Curtin’s (1996) discussion of “why good people do bad things” (p. 63), such as fearing exclusion from the work group, rejection anxiety, imagining terrible consequences attendant on doing the right thing, and failing to view such fantasies realistically. It might also have been the case, however, that the investigations failed to explore fully the contextual issues involved in ethical problem solving. One may also be drawn to consider the nurses’ two different styles of ethical problem resolution in relation to Kohlberg’s (1978) conventional and postconventional stages, or Gilligan’s (1982) conception of moral development as the move toward more caring, relational ways of resolving conflicting responsibilities. However, to date, research has failed to demonstrate moral development, measured by the DIT, as a significant variable in nurses’ moral actions.
The evidence already presented has suggested that becoming ethically active nurses is a developmental process. One study found nurses to express a feeling of responsibility for patients, conscience regarding ethical choices, as well as frustration and inadequacy in bringing about the best outcomes for patients (Sorlie, Kihlgren, & Kihlgren, 2005).

**Nurses’ Ethical Problems**

The following includes a discussion of nurses’ ethical problems focusing on evidence of how nurses become aware of ethical problems, the array of ethical problems that nurses may experience, and the types of actions that nurses take in relation to ethical problems.

*Nurses’ Awareness of Ethical Problems*

Nurses must become aware of ethical problems in order to act on them. Nurses who value the patients’ best interests or rights but observe that those interests or rights of are about to be violated may identify their concerns as ethical problems. In explaining how nurses are alerted of ethical problems, nurses may experience emotional reactions or feelings of unease or that something is not right in the nurse-patient relationship, which can assist the nurses to realize that their values are being violated and the patients’ interests are being threatened (Slettebo & Bunch, 2004). Nurses also can express ethical problems as conflict between their focus on the patients’ needs and goals as their primary focus and the interests of physicians (Ahern & McDonald, 2002; Liaschenko, 1993; Wolf, 1989).

Historically, the ethical problems of nurses have shifted from decision issues (i.e., what to do) to action dilemmas (i.e., how to bring about the right outcome): In the 1990s
nurses, were more likely to know what should happen but experienced great difficulty in bringing about what was needed (Wilkinson, 1997). Specific ethical theorists have supported the nurses’ focus on patients and patient concerns. For example, Nordvedt (1998) drew on the work of the French philosopher Levinas in postulating that ethics precedes ontology and epistemology. Nordvedt theorized that the nurses’ concern for their patients’ best interests reveals a core ethical stance of “being ‘for’ the other” that precedes knowledge of the patients’ situations gained through the ontology of “being with the patients.”

Nurses have identified an array of ethical issues that they sometimes have expressed in terms of the value that they have placed on patients’ autonomy (Hutchinson, 1990; Slettebo & Bunch, 2004). Nurses have reported ethical conflicts related to the incompetent or unethical behaviours of other health care providers that include unsafe care, undisclosed errors, verbal abuse of patients, and other actions viewed as threats to patients’ care (Ahern & McDonald, 2002; Enes & de Vries, 2004; Fry et al., 2002; Hutchinson, 1990; Redman & Fry, 2000; Schroeter, 1999; van der Arend & van den Hurk, 1999). Differences of opinion between nurses and physicians over patients’ treatment plans have constituted well-documented sources of ethical concern for nurses (Äström et al., 1995; Enes & de Vries, 2004; Erlen & Sereika, 1997; Hutchinson, 1990; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Sleutel, 2000; Sundin-Huard & Fahy, 1999; Woods, 1999). Nurses’ greater contact with patients may give them more knowledge of the patient’s needs and goals than is available to physicians, resulting in different and conflicting goals (Liaschenko, 1993; Wolf, 1989).
Researchers have identified fiscal restrictions on resources for patient care as causing ethical problems for nurses (Liaschenko & Fisher, 1999; Rodney & Varcoe, 2001). Inadequate time or other resources could hamper nurses in providing high-quality patient care, resulting in decisions about which aspects of care to eliminate; nurses who are aware that patients have received poorer-quality care could feel frustration, lowered job satisfaction, and a reduction in professional pride. Also important are the ethical problems that nurses could experience in attempting to reconcile professional knowledge of the care that patients should have received with an awareness of the lower possibilities within the organizational context at that time. Researchers have found each of these types of dissonance to constitute a source of ethical problems for nurses (Fry et al., 2002; Raines, 2000; Redman & Fry, 2000). Organizational decisions to reduce nursing resources available to patients, particularly during the 1990s, have caused nurses to feel devalued as they have struggled to provide the so-called invisible care considered unnecessary by others in the organization (Liaschenko & Fisher, 1999; Rodney & Varcoe, 2001). Nurses also have experienced stress while striving to deal with high workloads and inadequate staffing (Severinsson & Kamaker, 1999; Sorlie et al., 2005).

Ethical Problems Identified by Nurses

Nurses have identified an array of ethical problems in their care of patients; the situations of patients, representing different ages, developmental stages, levels of acuity and health concerns, may influence the types of ethical problems identified by nurses. Therefore, nurses’ ethical problems might vary depending on their clinical areas (Redman & Fry, 2000). Neonatal intensive care unit nurses have reported problems around decisions to enrol ill premature infants in studies or plans to transfer an infant whose
prognosis was uncertain (Spence, 1998). Operating room nurses’ concerns have related to patient consent to treatment, respect for patients, and competence of other care providers (Ceci, 2004a; Schroeter, 1999). In other clinical areas, problems have included conflicts between patient and family wishes (Åström et al., 1995; Redman & Fry, 2000) or uncertainty related to patients’ competence to make care decisions (Åström et al., 1995; Slettebo & Bunch, 2004). Military nurses, having been ordered not to provide needed care to civilians, have experienced ethical problems as a result (Fry et al., 2002).

End-of-life situations represent an important area of nursing practice. Nurses caring for terminally ill patients seek to express the international nursing value of assisting patients to a dignified and peaceful death, and the type of death the patient prefers. In end-of-life situations, nurses deal with various ethically charged issues, including decisions around information disclosure, substitute decision making, and euthanasia (Enes & de Vries, 2004; Georges & Grypdonck, 2002; Hutchinson, 1990; Lorensen, Davis, Konishi, & Bunch, 2003). Nurses caring for terminally ill patients enrolled in clinical trials also have expressed concern related to disclosure and conflicting goals (Krishnasamy, 1999). End-of-life concerns present nurses with known and uncertain ethical situations, resulting in nurses being torn between respect for patients’ autonomy, the requirement that patients be told their diagnoses, and the belief that too much detailed prognostic information may not always be what individual patients wish (Lorensen et al., 2003). Nurses have experienced similar ethical uncertainty in situations in which dying patients’ emotional needs change over time (Enes & de Vries, 2004), such as when nurses are concerned that patients’ nursing care is inadequate (Sorlie et al., 2005).
or when they believed that they are compromising their caring values because of other priorities in the work setting (Krishnasamy, 1999).

The foregoing discussion, although not exhaustive, does underline the breadth of issues that nurses can experience as ethically problematic situations. Nurses experience a wide range of ethical concerns in their practice that are related to others’ care of the patients and the nurses’ own care decisions. In addition to identifying such concerns, it is important to explore whether, why, and in what way those issues constitute ethical dilemmas for the nurses reporting them. The next section discusses research focusing on those questions.

*Nurses’ Actions to Resolve Ethical Problems*

Nurses who have determined resolutions to ethical problems apparently use a variety of actions to bring about the desired results for patients, actions that have varying implications for the nurses. The possible actions can be viewed as being less or more risky to the nurses; the potential for negative reactions of others, including physicians and/or members of the hospital administration, can be seen as influencing nurses’ perceptions of the riskiness of particular actions.

Research results have suggested that once nurses determine preferred outcomes to ethical problems, they use many strategies to bring about the desired patient outcomes. Some relatively safe nursing acts reported by researchers include documenting, running interference, delaying paperwork, and resorting to rigid policies on behalf of patients (Lützen & Schreiber, 1998). More overt and less safe strategies used by nurses in the best interests of patients include selectively ignoring orders, stalling; “contouring information” (i.e., emphasizing some points and deemphasizing others); encouraging
patients or families to act; and flexibly interpreting orders based on evaluations of the situations and possible consequences (Hutchinson, 1990). These actions often could resolve ethical problems and incur little risk to the nurses. A more risky behaviour occurs when nurses choose to overtly ignore physicians’ legal orders (Ahern & McDonald, 2002). Although not confrontational, this action could result in sanctions against nurses for not carrying out explicit directions.

Researchers also have found that nurses resolve ethical problems through verbal communication with others, including patients, families, physicians, and others. Nurses may provide information to patients and/or family members that would normally have been withheld or that would normally have been given by physicians (Redman & Fry, 2000). Nurses have far more contact with patients than physicians do, and they can be acutely aware of patients’ and family members’ need for information. The decision whether to participate in the withholding of information from patients could constitute an ethical problem for nurses, but providing information usually given by physicians could incur risk for nurses because that action may violate the hierarchical norms of the hospital.

Nurses also have confronted physicians about their plans of care for patients, acting on distress at the thought of patients receiving less than adequate care (Wurzbach, 1999). Such overt action to resolve moral dilemmas in practice are examples of taking a stand by speaking up or verbally confronting others (Sleutel, 2000; Wurzbach, 1999). By challenging questionable care plans, nurses may have brought about better care for the patients in their care, but they also may have risked sanctions for interfering in medical decisions. At times, nurses have decided, based upon their own clinical knowledge, to
refuse to participate in aspects of care with which they disagreed; unable to stop or alter procedures or treatments, nurses have sometimes determined to exclude themselves from being part of the ethical problem (Wurzbach, 1999). The decision to refuse to participate in any aspects of patient care, communicated as clinical disagreement with the physicians, could be quite risky for nurses. These examples from previous studies provide rich evidence of the moral problems that nurses encounter in practice; the interpersonal dynamics involved in the gendered space nurses occupy in hospital practice (Liaschenko, 1997); and nurses’ approaches when they find themselves caught between vulnerable patients and more powerful care providers.

The riskiness for nurses of overt behaviours to resolve ethical problems is a key factor in the decision of whether or not to act or how to act. Three factors help nurses to act in spite of the risk: (a) focusing on the needs of patients, (b) believing themselves to have obligations to their patients, or (c) feeling remorse at having not acted on previous occasions to resolve ethical problems for patients. Some nurses in previous studies have commented they were willing to take these risks because their nursing education had included instruction to speak up and/or because they knew that although the consequence of speaking could have included making enemies of the physicians involved, not speaking would have resulted in regret for not acting (Sleutel, 2000; Wurzbach, 1999). Previous research has suggested that nurses with prior experience in resolving moral dilemmas and who have displayed articulate communication are more likely to speak up and overtly challenge others (Äström et al., 1995; Martin, 1998; Schroeter, 1999; Wurzbach, 1999).
Nurses also can display a range of other behaviours in response to ethical problems, not all of which focus on resolving the ethical problems. Behaviours on the part of nurses, such as refusing responsibility while doing nothing or claiming powerlessness, deflect attention away from the ethical problems without solving them (Lützen & Schreiber, 1998). Some nurses’ actions not designed to bring about change on behalf of patients include failing to act, blaming others, blaming the organization, and shirking responsibility (Lützen & Schreiber, 1998). Other ineffective behaviours include subordination of self (Sleutel, 2000) as well as powerlessness and passivity (Ahern & McDonald, 2002; Åström et al., 1995; C. Kelly, 1998; Omery, 1985; Rubin, 1996) in nurses who fail to act to resolve ethical problems. These findings shed little light on the context in which nurses choose from among the alternatives available to them in resolving specific ethical problems.

Nurses may analyze specific situations to determine what options are available to resolve ethical problems. Nurses who are able to resolve ethical problems through less risky actions may decline to act in ways that incur very great personal or professional risk. Alternatively, it is possible that nurses find themselves able to take great risks at times because they believe that the risks are worthwhile; the same nurses may choose to do much less, or even nothing, in other situations if they believe that the risky actions would not resolve the ethical problems and would prove futile. Nurses might choose to compromise when practical, protest others’ actions when feasible, or subvert orders overtly or covertly (Woods, 1999). Woods (1999) concluded that although nurses’ decision making seems to be emotionally rather than rationally based, there has been no evidence of irrationality in that emotion; rather, it has shown empathy and intuition, and
could be seen as reflecting phronesis or practical wisdom. In another study, nurses in a nursing home used negotiation to preserve patient autonomy; explanation to support patient understanding; and, on rare occasions, restraint or other coercive actions, but they showed reflection and the use of previous experience to inform immediate situations (Slettebo & Bunch, 2004).

Nurses at times have engaged in whistle-blowing actions to protect patients, risking their reputation as loyal employees and coworkers in an effort to draw attention to threats to patients. Ceci (2004a) reported on concerns expressed by nurses at St. Boniface Hospital in Winnipeg, Manitoba, about high infant mortality associated with a particular paediatric heart surgeon’s care. Those nurses testified in an inquest that they persistently used a number of strategies to resolve their ethical concerns. The approaches included directly intervening when possible; carefully documenting, discussing, and preparing submissions for meetings; repeatedly attempting to communicate within the hospital hierarchy to draw attention and action to the problem; and forming alliances with other health professionals (i.e., anaesthetists) to force action on the problem (Ceci, 2004a).

The research literature has portrayed a continuum of nursing action in response to ethical problems ranging from complete inaction through interpersonally and organizationally “safe” behaviours such as documentation and use of policy, through a range of communication and bureaucratic strategies to “slow down” outcomes seen as negative for patients, to overt refusal, confrontation, or whistle blowing. However, there remains an inadequate understanding of those actions in terms of nurses’ understanding of ethical problems and in terms of supports and barriers to nurses in resolving ethical problems.
Supports to Nurses’ Ethical Problem Solving

Researchers have identified some factors to help nurses to resolve ethical problems. For example, nurses have expressed a feeling of responsibility for patients, conscience regarding ethical choices, as well as frustration and inadequacy in bringing about the best outcomes for patients (Sorlie et al., 2005). Some researchers have found discussion with peers or supervisors to be part of nurses’ development of ethical sensitivity and problem-solving ability (Fry et al., 2002; Hart, Yates, Clinton, & Windsor, 1998). A few researchers have pointed out that nurses’ reflection on previous ethical problems can help in the development of ethical problem solving (Lorensen et al., 2003; Woods, 1999; Wurzbach, 1999). Nurses have retained memories of previous ethical problems and have continued to reflect on them for over 20 years (Woods, 1999). Although some researchers have viewed ethical problem solving as a linear process, their results have not generally supported such depictions. Some researchers have focused on the strategies that nurses use in ethically problematic situations as reflections of a decision-making process, but they have not clarified how the nurses decided to act.

Combinations of cognitive, philosophical, and personal factors have been postulated, but without a clear view of their relation to one another.

Barriers to Nurses’ Ethical Problem Solving

This section discusses barriers to or constraints on nurses’ ethical actions, including attention to work environment factors of work intensification and health care restructuring. Since the 1980s, increasing attention has been paid to the role of an oppressive hospital work environment in nurses’ ethical choices (Falk Rafael, 1996; Liaschenko, 1993; Liaschenko & Fisher, 1999; Omery, 1985; Peter, Macfarlane, et al.,
2004; Varcoe et al., 2004; Yarling & McElmurray, 1986). An important area of exploration has focused on the modern hospital as a social organization in which work roles, power relationships, and hierarchical structures have an enormous impact on nurses’ ethical choices. Likewise, investigations of health care restructuring also have revealed barriers to nurses’ ethical decision making.

A ground-breaking study of hospital nurses and ethical decision making found that nurses carried out multiple and often conflicting roles in their work, experienced conflict with other care providers, and experienced power conflicts regarding objectification of patients (Chambliss, 1996). The results suggested that ethical problems in health care organizations arise because of power conflicts between occupational groups and their representatives; mislabelling of fundamental conflicts between groups as ethical conflicts; groups’ different moral agendas; increased status of groups such as nursing; and new, changing issues (e.g., HIV). The results challenged the myth of autonomous ethical decision makers in modern hospitals, emphasizing the critical importance of the organizational context to individual ethical problem solving. Chambliss also found that nurses’ ethical problems included concerns about the exercise of power in what was allowed to be defined as problems, how to resolve problems, and how the discussion was disseminated. This study linked the undervalued, subordinate role of nurses with ethical problems in which nurses were constrained from doing right.

The results of Chambliss’s (1996) study had resonance in another investigation that focused on the whistle-blowing role of nurses in a high-profile case of infant deaths (Ceci, 2004a). The inquest into the deaths of several infants at Winnipeg’s St. Boniface Hospital revealed repeated attempts by the nurses to bring forward concerns that a
surgeon’s incompetence was causing unnecessary infant deaths: The silencing and discrediting of the nurses by medical and hospital authorities seriously delayed the needed inquiry and resulted in further infant mortality (Ceci, 2004b). Analysis of this case used Foucault’s notions of power to analyze competing truth claims used by physicians as barriers to the nurses’ ethical action (Ceci, 2004b).

More recently, attention has been paid to the importance of interpersonal relationships in the resolution of ethical problems related to patient care; these relationships are not only between caregivers and patients but also between caregivers and others (Bergum, 2004). Themes related to an action-oriented “relational ethics” (Bergum, 2004, p. 486) have been developed through investigations that have focused on the environmental context as a key variable and have added the concepts of embodiment, mutual respect, and engagement to the action-focused approach to nursing ethics. Bergum’s (2004) emphasis on relationships harkens back to Smith and Davis’s (1980) early focus on the multiple and sometimes competing obligations experienced by nurses as they attempted to resolve ethical problems and tried to move the dialogue forward by recognizing the importance of various perspectives, particularly those of patients, in effectively resolving ethical problems about patients’ care. Although this approach recognized realities of nurses’ work context, it was silent on the issue of organizational resource distribution or health care restructuring.

Health care restructuring has proceeded since the late 1980s in Canada, the United States, the United Kingdom, and other countries. Health care restructuring has led to increased nursing workloads as the nurse-patient ratio has deteriorated (Canadian Nursing Advisory Committee, 2002; Denton, Zeytinoglu, Davies, & Lian, 2002) and has
dramatically decreased nurse job satisfaction (Aiken et al., 2001; Blyth, Baumann, & Giovanetti, 2001; Laschinger, Sabiston, Finegan, & Shamian, 2001). Bed cuts have led to fewer but more acutely ill patients cared for by fewer nurses in Canada (Shamian & Lightstone, 1997) and the United States (Sochalski, Aiken, & Fagin, 1997). Research (e.g., Canadian Nursing Advisory Committee, 2002) has revealed a web of overwork, frustration, and nurses’ attempts to provide quality nursing care in adverse circumstances. Most recently, evidence has shown that hospital restructuring and increasing nursing workloads have resulted in not only a poorer quality of patient care but also increased patient mortality (Aiken et al., 2002; Clarke, 2004). Nurses have expressed concern that increased workloads have reduced the time available to work through ethical concerns (Rodney & Varcoe, 2001; Severinsson & Kamaker, 1999; Sorlie et al., 2005), with some having concluded that Canadian nursing work settings are “morally uninhabitable” (Peter, Macfarlane, et al., 2004, p. 356), a dramatic if contested view (Paley, 2004).

The reviewed literature that was discussed in this section has provided very credible evidence of deterioration in nurses’ work situations through the 1990s in numerous countries by highlighting increasing moral distress among nurses resulting from increased workloads, inadequate resources, invisibility of nurses’ emotional and coordinative labour, and evidence of inattention to nurses’ concerns. What this research has not clearly portrayed are the ethical choices that nurses have actually continued to make in working through ethical dilemmas in the face of health care restructuring and increased workloads, conflicts in values between nurses and physicians, and continued oppressive hierarchies and power relationships.
Conclusion

The reviewed literature has revealed considerable interest in nurses’ ethical problems, deliberations, and actions, and has yielded much useful information. The breadth of situations deemed by nurses to be ethically problematic is considerable, the central ethical issues for nurses often are expressed as concern over their ability to ensure that their patients’ best interests are reflected in the outcomes, and nurses’ conflicts with physicians in particular constitute a significant body of these ethical problems for nurses. The reality of competing obligations, the need to work effectively with others, and the connection between the nurses’ own qualities and those of the organizational context have not been fully investigated.

In addition, the literature has shown particular interest in both nurses’ moral reasoning and how nurses work through ethical problems. However, research to date has failed to yield clear answers. Nurses’ work in resolving ethical problems seems to be helped by specific personal qualities, education, experience, and particular qualities of the work setting, but research continues in that area. Likewise, there is good evidence that those same qualities in converse can interfere with nurses’ resolution of ethical problems. In addition, a number of researchers have identified differences between nurses who did and who did not act on the result of their ethical decisions, but the question remains how some, but not other, nurses became ethically active and competent. Finally, recent work has begun to focus attention on the relational quality of nurses’ ethical problem solving.
CHAPTER 3: METHODOLOGY

This study focused on registered nurses’ perceptions related to ethical decision making. The design selected for this study was a qualitative research methodology to ensure adequate exploration of the participants’ perceptions. This qualitative study should not be evaluated using the criteria used to evaluate quantitative studies, such as internal and external validity, reliability, and objectivity, but rather by the usual criteria for qualitative studies, including credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Marshall & Rossman, 1989). The investigator addressed these criteria in the preparation of the proposal and protocol for this study. Previous research has revealed that registered nurses in acute care hospitals experience moral distress and/or constrained moral agency resulting at least in part from the workplace context.

This investigator wished to explore nurses’ ethical problem solving from the perspectives of the nurses themselves. Therefore, this researcher determined that two hospitals possessing different characteristics and different workplace contexts would offer an opportunity to compare nurses’ experiences in two different acute care settings. In this way, it was possible to differentiate between characteristics unique to the individual organizations and characteristics shared by hospitals that varied in size, geography, and mandate. Within the acute care setting, the study was limited to adult inpatient units to provide consistency of the nurses’ patient care experiences and transferability of the research findings. The study excluded nursing settings other than acute care hospitals in order to increase the transferability of the findings. Two hospitals were selected for the study. One was a large Ontario metropolitan medical teaching hospital, and the other was a smaller community hospital in a smaller Ontario city.
The study included 10 registered nurses working in the hospitals but excluded other levels of nursing personnel such as registered practical nurses or nurse practitioners because the relevant literature focused on issues related to the experience of registered nurses. Exclusion of inexperienced nurses, for example, ensured greater transferability and dependability because the nursing ethics literature has documented the different perspectives of experienced and inexperienced nurses. A target of 10 to 14 participants was set to ensure a range of perspectives and experiences but prevented the collection of so many data as to prevent the investigator from analyzing the data effectively.

The data collection method used was a single face-to-face or telephone interview rather than a focus group or survey. The privacy of individual interviews and the richness of the data that could be gained by an interview versus a questionnaire increased the credibility, dependability, and confirmability of the study. The participants were asked to discuss circumstances in which they were able to resolve ethical problems as well as instances in which they were unable to resolve ethical problems. This aspect of the methodology added to the credibility, transferability, and confirmability of the study results.

The investigator selected bedside nurses to ensure a focus on the experiences of nurses with patients assigned to them for care. The study excluded nurses in management and educator roles because they do not have the direct nursing care of individual patients within their responsibilities. Research has revealed that inexperienced nurses' perceptions of ethical issues are different from those of more experienced nurses; therefore, inclusion in this study was limited to nurses with more than 5 years of experience. The proposal for this study addressed the protection of human participants, including provision of
information about participation in the study, risks and benefits, protection of anonymity, and informed consent. Ethical approval for this study was granted by the University of Toronto’s Research Ethics Board, including permission to contact possible research site hospitals. The administration of two hospitals were approached, and with their approval, the proposal and protocol for the investigation were submitted for review by each hospital’s research ethics board; both gave permission for the study to proceed in their organizations.

Following ethical approval, the investigator advertised the study on the selected nursing units, and the investigator was available on each unit to answer questions. Potential research participants viewed an information sheet on a bulletin board in the nurses’ conference room on the nursing unit where they were employed (see Appendix A). Potential participant registered nurses identified themselves by contacting the investigator in person, by telephone, or by e-mail. Potential participants received an explanation of the study (see Appendix B), and if they agreed to participate, they completed and returned the informed consent form (see Appendix C). The amount of time taken to review the explanation prior to returning the consent form was at the discretion of the potential participant.

Numerous nurses in both organizations reviewed the information sheet describing the study. A number of nurses expressed interest in the study but ultimately declined to participate, with several indicating that the time commitment of 1 to 1.5 hours was too great. Ten nurses, 5 in each hospital, agreed to participate in the study and signed consent forms; all of the nurses who agreed to participate were included in the study. Each participant participated in a single, audiotaped, face-to-face or telephone interview that
lasted between 1 and 1.5 hours. The first 3 were face-to-face interviews (two in the researcher’s office and one in a participant’s home), and the investigator carried out the remaining 7 interviews by telephone. The interviews occurred over 14 weeks between late September 2005 and early January 2006.

In preparing the research protocol, the investigator developed an interview schedule that included specific questions designed to function as prompts during the interviews (see Appendix D). The prompts were based upon the initial conceptual framework and the research questions. The preparation of the interview questions reflected the research questions that the investigation sought to explore. For example, the investigator asked the participants to consider a situation in which they recognized an ethical problem in their practice. In relation to that problem, the investigator asked the nurses in the study to describe the qualities in themselves that made them see the problem as being an ethical one. The investigator also asked the participants to discuss aspects of the particular workplace context that influenced the nurses’ perceptions of the problem as an ethical one. Likewise, the investigator asked the nurses to consider their own characteristics and those of the hospital as influencing how the nurses worked through the problem, viewed the riskiness of particular options, decided to act, and perceived outcomes of that action.

Then the investigator asked the participants to reflect on a circumstance in which they identified a situation as being an ethical one but chose not to act. Similar areas were explored, including how aspects of the nurses and the workplaces influenced the following: the nurses’ views that the problem was an ethical one; ways in which the
nurses worked through the problem and viewed the riskiness of specific options, decided not to act, and viewed the results or consequences of that inaction.

An individual hired by the investigator transcribed the audiotaped interviews; the transcriber did not have access to the identities of the participants; following interview transcription, the researcher destroyed the audiotapes. Only the investigator and the investigator’s supervisor had access to the transcribed interviews. Following each interview, the investigator assigned each participant a number that was used during audiotape transcription, data analysis, and preparation of a report. The investigator reviewed all interview transcripts for accuracy and for any information that could identify any person; upon finding such information, the investigator removed it in another draft of the transcript; the investigator maintained each initial transcript with the consent forms under double lock. The investigator’s supervisor had access to anonymous data during the data analysis and report-writing stage. No other person had access to the data following data transcription.

The investigator secured the consent forms and transcribed hard copies of interviews under double lock, where they will remain until December 2012, at which time the investigator will destroy them. The investigator retained the coding scheme for 1 year under lock and key at a location distinct from the location where the transcripts are stored and then subsequently destroyed it. The data maintenance documents and worksheets did not contain any information that could identify any person. The investigator and her supervisor exercised extreme caution to ensure the privacy and anonymity of the participants.
Quantitative methods such as inferential statistical analysis were inappropriate for this study. In this qualitative study, data analysis proceeded as follows. Prior to data collection, the investigator developed an initial coding system based upon the conceptual framework and research questions. Interview tapes were transcribed, and data sets were reviewed individually and in comparison to one another. The data were analyzed manually by the researcher. The participants’ descriptions of specific ethical problems and the participants’ perceptions and actions were analyzed for common themes; the participants’ narratives were compared with the other narratives. Within-case and between-case displays were created; repeated readings of these, as well as rereading of the transcripts, revealed the themes evident in the findings.

Key themes that emerged included concern for the patients, protection of the patients from the actions or decisions of others, multiple and complex relationships with others, and risk/riskiness. Early in the data collection period, it became apparent that the participant nurses experienced their workplace and, in particular, ethical problems as interpersonal relationships with others. Thereafter, in more detailed data analysis, particular attention was paid to the nurse participants’ relationships with others in the workplace and the impact of those relationships on the nurses’ responses to and actions related to specific types of ethical problems. Initial coding and subsequent, more detailed coding reflected the importance of interpersonal relationships to these nurses in their ethical problem resolution. Within the overall theme of interpersonal relationships, specific types of workplace interactions were revealed as supports and/or barriers to the nurses’ ethical problem solving. Viewed together, the data reflected a complex array of sometimes competing relationships experienced by the nurses.
Through this process, the initial conceptual framework for the study was altered and refined, with a greater emphasis on the role of interpersonal relationships as the nurses worked through ethical problems. The initial conceptual framework failed to completely explain the exhibits of condensed data, and the investigator carried out checks of the data considering alternative hypotheses (Miles & Huberman, 1994). The investigator decided to alter the conceptual framework on the basis of the emerging study findings, an action that added to the confirmability of the study results.
CHAPTER 4: QUALITIES OF NURSES AND ETHICAL PROBLEM SOLVING

The investigator undertook this study to ascertain how the qualities of individual nurses and the characteristics of their employing organizations influenced the nurses’ ethical problem solving. In this chapter, the focus is on the study participants’ descriptions of the experiences that shaped their approach to identifying, contemplating, and resolving ethical problems. Through discussion of ethical problem solving, these nurses revealed the qualities and values that they held in relation to patients, the patients’ families, and other health care providers.

All of the nurses discussed the important role of nursing experience in developing their ethical views as well as closely related areas such as nursing knowledge, clinical competence, and confidence in their nursing judgement. Far fewer participants described any specific types of personal experience as having influenced their ethical decision making, whether those personal experiences arose from family members’ illnesses, the nurses’ developmental experiences, or religious beliefs.

The participants expressed concern for the patients in their comments, suggesting that they possessed moral/ethical sensitivity (Benner et al., 1996). Their professional experience seems to have contributed to their ability to recognize the ethically salient issues, particularly patient care situations (Benner et al., 1996). In addition, these nurses described their concern for physicians, patients’ families, and other health care providers. While wishing to protect patients and others, the nurses experienced conflicts that contributed to the ethical problems that they identified, namely, the conflicts between protecting patients and protecting others: physicians, family members, and/or coworkers. The identification and resolution of those ethical problems occurred in a complex
relational milieu, where the nurses sought to engage with an array of others to bring about the patients’ best outcomes while avoiding harm to others; this search, for the most effective, respectful interaction, is a hallmark of relational ethics (Benner et al., 1996).

The nurses described approaches to others in dealing with ethical problems that they had developed following particular nursing experiences. Ethical decision making was, for these nurses, deeply developmental. It involved increasing knowledge of self over time, as well as increasing knowledge of the organization and others within it. The nurses’ ethical decision making was context specific and strongly socially situated. The following discussion explores each of the aforementioned areas in greater depth and with evidence from the research participants. Prior to discussing how these nurses described their relationships with patients, physicians, families, and others, it is important to present the nurses’ descriptions of themselves, including their comments about the origins of their ethical beliefs and motivations. Nurses in this study discussed their personal and their professional backgrounds in shaping their ethical beliefs and, ultimately, their ethical actions.

Impact of Personal Background on Ethical Action

Some of the nurses described particular personal experiences that influenced their ethical problem solving: 3 mentioned family illness, 4 discussed other developmental experiences, and 4 mentioned religious beliefs and values. In all, 7 nurses described the impact of some type of personal experience on their resolution of ethical problems, although a minority of the nurses mentioned particular personal experiences.
Family Illness Experience and Nurses’ Ethical Values

Three nurses mentioned specific personal experiences with a parent’s or a grandparent’s illness and described how such experiences increased the nurses’ ability to relate to patients and their families. For 2 of these nurses, these events seemed to increase their empathy for the families of patients. Participant 1 reflected on her grandmother’s death:

I think the background with my grandmother . . . you see another family going through the same thing . . . it just makes it . . . you’ve walked a mile in their shoes . . . I guess it’s just your morals and how you’ve been brought up; how you would want your family members to be treated.

Participant 5 discussed a personal experience related to her father’s death:

When my dad passed away, we didn’t have him resuscitated, and we realized that there was nothing that medicine could do to make him better. . . . so for me, that feeling, that strong feeling, comes personally from my experience I had with my dad, and that has carried over.

Both of these nurses described personal experiences with family members’ illnesses and health care decisions. Participant 10 supported this point. She recounted her experience with her own mother’s decision to refuse continued treatment and how that experience increased her awareness of such sentiments in the patients in her care:

Probably I got that from when my own mother had been ill and the doctor telling her all the time, “Well, you have to do this, you have to do that”; and she’d talk to me and I’d say, “Well, you don’t have to, Mother, if you don’t want to.” You know, like, “You can refuse to have it done.”

All of these nurses described ways in which their experience with family members’ illnesses had informed their later nursing practice with other patients and families. It is important to note that although these nurses underlined the importance of these experiences, the other 7 nurses did not mention family illness as a formative experience.
Nurses’ Developmental Experiences and Ethical Values

Four participants described general aspects of their development and upbringing that influenced the values they brought to their encounters with patients. This background included moral development and family teachings: “I guess it’s just your morals and how you’ve been brought up; how you would want your family members to be treated” [Participant 1]; “You know, you wonder, did your parents instil it in you somehow. I’m not so sure about . . . I mean, my parents are good people too, so maybe they did instil it a bit.” [Participant 9]; “[M]y mother used to always say – my mom just died – ‘We’re all God’s children.’ . . . So you don’t treat anybody any differently” [Participant 2].

Each of these 3 nurses identified aspects of their upbringing as important sources of their caring nursing values. However, it was difficult to discern exactly how important these experiences had been in comparison with professional experience, a factor that all of the nurses mentioned. Participant 3 described a developmental background that was more complex and included educational and other life experiences: “I think it has a lot to do with spirituality and ethics has a lot to do with spirituality because I think that from what I’m seeing, anyways, that the older I get, the more that part of me is developed.”

All of these nurses described aspects of their development, whether within the family or more general, as influencing the development of their ethical values and their potential for ethical action on behalf of patients. None of the other nurses mentioned their developmental background as having a direct impact on their ethical decision making.

Religious Belief and Ethical Values

Four of the nurses identified their religious beliefs as having some impact on their nursing practice and their approach to ethical problems. Participant 1 identified several
possible influences, including religious values, by noting, “I felt comfortable doing what I was doing, whether it was experience, whether it was morals, whether it was religious background. I think all of that just played a part, for sure.” Participant 2, when asked what about her as a person influenced her concerns related to an end-of-life situation, stated, “Probably my own faith, which is an important thing. Certainly killing somebody isn’t something ethical to do.” Participant 8, who spoke of a specific religious teaching as guiding her practice, stated, “And so, I basically try to follow that adage that is consistent throughout various religious teachings, which basically is some variation of ‘Do unto others.’ ” These 3 nurses recognized that their own religious background and beliefs had at least some influence on their approach to ethically problematic situations. Participant 10 spoke more explicitly about her religious beliefs, including how those beliefs influenced her own preferences, in terms of her own end-of-life decisions: “[I]t is my faith background that comes into play at the same time. I see a better place that I’m going to when I die; and I can’t see putting myself through all of that there.”

These brief comments indicated that these 4 nurses identified their own religious background as having an impact on their relationships with patients and their approach to ethical problems. However, 6 participants did not mention their own religious beliefs; furthermore, the brevity and, in some cases, the hesitancy of these 4 participants’ comments suggested that caution must be exercised in drawing any conclusions about the relative importance of religious beliefs on ethical problem solving in this group of nurses.

Seven participants described one or more of the following as influencing their ethical sensitivity and problem solving: previous learning involving family illness experiences, developmental life experiences, or religious beliefs. However, the majority of
participants did not identify any of these factors as being among their personal qualities relevant to ethical problem solving.

Impact of Professional Background

In contrast to the last section, all of the participants in this study described professional nursing experience as an important aspect of themselves in considering patient care situations where ethical problems were evident. The nurses’ clinical background provided them with experience that they believed helped them in recognizing and analyzing ethical problems. Several nurses spoke of the importance of their clinical experience: “I think it just comes again with experience with the patients and the families that I’ve had” [Participant 1]; “But the patient didn’t need that morphine, so as an experienced nurse, I chose to do that [i.e., not give the morphine]” [Participant 2]; “You know, once you’ve worked around sick people enough, you learn to look at a person and just walk into a room and say, ‘There’s something wrong with this person’ ” [Participant 3]; “I think maybe my experience” [Participant 5]; “because I’d had previous experience, as had other people, so, yeah, previous experience suggested to me that this was going to be . . . this might not turn out the way everyone had hoped.” [Participant 7].

Most of the nurses in this study elaborated on how their previous experience led them to see patients’ situations and needs in particular ways. Two nurses spoke specifically about ways in which previous negative experiences had informed their subsequent perspectives on ethical problems. Participant 1 stated:

“[I]t’s from, I suppose, experiences that I’ve had with people that have just plain said, ‘Enough is enough. I don’t want anything else done.’ . . . I’ve seen invasive things being done in the past that’s really bothered me after the fact.”
Reflecting on those memories contributed to the participant’s current willingness to deliberate on, discuss, and act on situations to bring about the best outcome for the patient.

Participant 9 echoed this emphasis on review of past ethically problematic situations by stating, “Yes, in one way knowing that, in the past, that things I didn’t resolve properly bothered me later. I’m going to make the effort not to have to be bothered by something . . . like it’s an inner conscience.”

Both of these nurses indicated the importance of reflecting on previous negative care situations that informed their later approach to ethical problems. In particular, reflection resulted for some nurses in feelings of guilt, regret, and remorse related to failure to act in their patients’ best interests. These feelings spurred some participants to subsequent action in resolving ethical problems in patients’ interest, partly in order to avoid those feelings.

Nurses recognized that their practice had evolved with experience and professional development, and some participants spoke of how their nursing practice and approach to ethical problems had changed with experience:

[A]s a new grad . . . . I didn’t know what’s expected. I probably didn’t realize that [giving unnecessary narcotics to hasten death, without a clear directive from the patient] is the wrong thing to do, in my opinion, and I may have given it. [Participant 2]

Other participants reflected on ways in which reflection on experience informed their ethical actions: “I don’t think I would’ve recognized what was wrong with him” [Participant 3]; “And you have to kind of think, “That’s where I was at, at the time because of the experience that I’ve had. I feel that I did the best that I could’” [Participant 1].
Others spoke of the ability they had developed to predict future outcomes subsequent to developing nursing experience: “You know that it’s going to end up not being a good situation; and it usually never does” [Participant 5]; “[O]f my 8 years, 6 of them have been in the [current unit], and I’ve seen a fair amount” [Participant 7]. Participant 8 described how this experience informed her practice in end-of-life situations:

By virtue of the job that I do and being in that environment, I know the difference between when withdrawal of care is an option and when withdrawal of care is . . . really irrelevant, because death is going to come, no matter what.

In these ways, the nurses described differences in their current abilities as nurses compared with their early nursing practice. Each of these nurses drew attention to the role of experience as they discussed ethically problematic situations.

Experience allowed Participant 4 to recognize problems in patient care as she viewed a procedure carried out with insufficient anaesthesia:

Is it because it’s a new protocol and because you don’t have to have an anaesthetist anymore? Now they give a wee bit of Fentanyl . . . like, we’re really giving them a shock and they’re remembering; there’s a problem there.

It was only the nurse’s previous experience with patients receiving adequate analgesia during the procedure that allowed the problem of insufficient anaesthesia to become clear. Participant 10, with several decades of nursing experience, reflected on how her nursing background not only assisted her in acting when necessary but also provided a historical perspective on situations in which such action was now more rarely necessary:

“I think because I’ve been working that long, yes. I think it does have a lot to do with it because I’m comfortable with who I am; and I’m comfortable with the value system that I have.”
All of the aforementioned nurses described ways in which their clinical experience, including experience with previous ethically troubling situations, had contributed to their ability to recognize later ethical problems. Reflection on poorly resolved or unresolved ethical problems continued for these nurses for many years; those previous experiences served to increase the nurses’ likelihood of acting; it also seemed to add strength to their concern for their patients. Several nurses invoked professional clinical experiences as increasing their likelihood of recognizing and acting on ethical problems.

Nurses’ Confidence and Ethical Values

Five of the nurses made an explicit link between their clinical confidence and their choices of how to act in ethically problematic situations. Participant 3 linked clinical confidence with clinical experience, leading to a willingness to act on behalf of the patient: “I’m pretty sure of myself because of my experience, so I’ll put my name out on the line. I’ll go do it.” Participant 2 described how her confidence led her to interact with other health care providers in an assertive manner, again on behalf of the nurse’s belief about the patient’s best interest:

I have the confidence to know my judgement. I have the confidence to be able to go to Dr. ___ and say, “I totally disagree with what you’re suggesting.” I have the confidence to go to my colleagues and not be looked at as a troublemaker, and I have the confidence to say to the . . . patient’s family, “It is ordered every hour, but I don’t think she needs it” . . . . but a new grad wouldn’t have had that confidence.

This nurse contrasted her own level of confidence with the lack of confidence many new nurses experience, and she recognized her professional clinical experience as the basis for that confidence. One other nurse, while not explicitly describing herself as confident, said, “I know that once I have the knowledge, I can go in to work and I could
handle any situation and not be intimidated and not be scared” [Participant 6]. That nurse’s comments suggested that she would be able to focus on her patient’s needs without concern related to her preparation to care for the patient. Participant 9 indicated that she would act if necessary without concern for others’ reactions just to avoid remorse at a later point:

> And I guess a part of me isn’t fearful of making waves, that if it’s to do the right thing, I’m going to say something and move forward, because I think, later, I’m going to have to live with the fact that we didn’t make the right decision, what was morally right.

Participant 8, who had less clinical experience, discussed how a lack of confidence could inhibit the nurse from acting:

> I’m probably not as confident as I could be, though I sometimes question whether or not I’m right, and therefore, I question whether I should be continuing to push in whatever direction I’m pushing . . . . there’s a little bit of insecurity in my own knowledge base.

That nurse’s hesitance seemed to reflect a lack of confidence around adequacy of knowledge and correctness of the nurse’s position.

These 5 nurses discussed ways in which confidence influenced their willingness to act in ethically problematic situations. These nurses saw confidence as based upon clinical knowledge and experience. Without confidence, the nurses would have been more likely to hesitate or question themselves, reducing the likelihood of approaching or confronting others in order to resolve ethical problems. Some of these nurses also indicated that their confidence contributed to their assertive interpersonal approaches in relation to other health care providers.
Ethics Education and Ethical Values

Only 2 nurses mentioned ethics education as a factor in their recognizing or deliberating about ethically problematic situations. Participant 2 discussed how the in-service education experiences that she had had at another hospital had informed her ethical action:

I have been to a couple of in-services on ethics, especially at [other hospital] . . . . and they show you both sides . . . . having the knowledge is really, really a bonus, and the experience, because I just went with my gut, and that’s what I did.

Participant 9 recalled content on ethics in her nursing education:

I remember in ethics class there’s different kinds of ethics, although I don’t remember them all; the greater good, and all that stuff, so maybe in a way, I was still kind of driven by ethics in one way . . . it was my ability to look at the bigger picture and looking at different possible approaches, I guess.

Both of these nurses spoke positively about the ethics education they had received. Some of the other participants would have graduated from their nursing education prior to the late 1970s and early 1980s, the period when content on bioethics, that is, ethical theories, principles, and decision making, began to be a usual part of the nursing curriculum. Other nurses educated much more recently may have graduated from programs with ethics content that was insufficient or inadequately related to clinical practice experiences. It also is possible that formal ethics education in ethical theories and principles provided scant assistance to nurses seeking to bring about the resolution of ethical problems in patient care because it was clear from the findings of this study that ethical problem resolution is strongly socially situated.

The nurses described attributes relevant to their ethical decision making as personal and professional. Personal attributes, gained through the experience of family illness, other developmental experiences, and religious beliefs, seemed to be of some
importance to some of the participants; however, it was unclear to what extent these factors influenced the nurses’ ethical problem solving. On the other hand, the major relevant professional attribute described by the nurses was nursing experience; all of the participants discussed the role of clinical experience and knowledge in their ethical problem solving in their identification and resolution of ethical problems. Five nurses mentioned professional confidence and seemed to relate confidence to clinical experience. Only 2 nurses discussed the impact of previous ethics education on their ethical problem solving. It may be that previous formal ethics education provided little assistance because the resolution of ethical problems is deeply interpersonal and socially contextual.

Focus on Patients and Patients’ Best Interests

All of the nurses spoke about their concern for patients and, in most cases, the patients’ best interests. Their comments reflected a high priority on engaging with patients and maintaining caring relationships with them; this included engaging in any way possible with patients who were unable to respond to the nurses’ caring approaches. The participants often described end-of-life situations, in which their recognition that the care providers were not meeting the patients’ needs constituted an aspect of the ethical problem. Nurses made statements about the importance of the focus on the patient:

“[P]atient care for me is very personal and any patient that I take care of, it’s very important that I do the very best for that patient that I can” [Participant 5]; “I’m human . . . to the patient, that’s in the first place how you got there. You have to be caring. You don’t acquire these things” [Participant 6]; “I would just look at the ultimate comfort for that patient” [Participant 1]; “[Y]ou’ve got to look at what’s to the benefit of the patient”
Each of these nurses spoke of the importance of the nurse-patient relationship as a key focus of their care.

Some nurses saw the decisions entailed in selecting treatment options as posing challenges for patients. The nurses discussed the focus on the patients’ best interests in the general context of patients’ choices around the type and extent of treatment for their health concerns. Participant 10 ensured that patients had the opportunity to understand options and ensure that health care providers respected their preferred options. This statement reflected the right of the patient to self-determination.

This is your right as a patient to say “no” to treatment, so that is something that you need to sometimes make aware to people as well . . . . you want to make sure people are aware that they don’t have a lot of time.

By engaging in and maintaining relationships with their patients, these nurses were able to discern and work to bring about the patients’ wishes and/or best outcomes. The focus on their patients and the patients’ best interests expressed by the nurses constitutes a key aspect of ethical nursing practice and is consistent with nursing practice standards (CNA, 2008) and other research results (Erlen & Sereika, 1997; Fry et al., 2002; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Wurzbach, 1999). All of the participants expressed concern for the patients and their situations, although not all participants provided explicit statements of this concern.

Two nurses, although not using language of concern for the patients’ best interests, described the distress they experienced while witnessing situations in which they believed physicians’ care decisions had violated patients’ best interests. In the first example, Participant 4 expressed frustration at not being able to bring about a comfortable, pain-free experience for the patient, instead having to witness unnecessary discomfort of a patient.
when treated by a physician: “The outcome really is the same, whether you say anything or not. But the thing that really is bothersome is that they had pain, and they shouldn’t have had pain . . . . That’s wrong.” In the second example, Participant 7 had worried that the physician would not be able to perform a procedure safely and, feeling unable to prevent the physician from going ahead, experienced remorse at the outcome: “I mean, the man was talking to me before the incident, and now he’s possibly going to be a vegetable. I don’t know how to cope with that, I really don’t.” Both of these participants, having developed trusting relationships with their patients, expressed dismay at being unable to prevent negative outcomes of medical treatment that they believed to be unnecessarily harming patients. Avoiding or preventing harm to patients was as important as bringing about good for them.

Four participants used the concept of empathy, explicitly or implicitly, in their discussion of the focus on the patients’ needs. Participant 3 described empathy as the basis for nursing ethics and for nursing care: “The whole idea of ethics is, you know, caring enough to be able to put yourself in that person’s situation or that family’s situation.” Participant 8 stated, “I have a respect for other human beings, period . . . And I feel very, very strongly about my role as an advocate for people who can’t speak for themselves.” Participant 2 reflected similarly:

I just remember it just took so long for her to get her pain under control, and I wasn’t going to back down from that . . . . Her big fear was to have lots of pain. She didn’t want to die having lots of pain.

These participants emphasized the role of empathy in the development of relationships with patients. This expression of the caring approach that they took with
patients underlined the importance to these participants of engaging in caring relationships with patients.

Being prepared to accept and respect others’ beliefs and perspectives constituted an important aspect of the nurses’ ability to focus on and fulfill the patients’ wishes. Participant 6 recounted an example from her nursing education to describe the challenge that other nursing students experienced in behaving empathically:

In nursing school, when we had our classes, some nurses would oppose certain things, and you could tell what they would be like when they go out there into the work field . . . . They have to respect each other’s values, the patient’s wishes and values.

Participant 1 discussed how she conveyed the concepts of respect and empathy to students in her clinical teaching role:

I would say to them, “He was somebody’s father, somebody’s dad, somebody’s uncle” . . . . There’s a lot of people out there who don’t share these types of everyday type of Canadian advantage. That doesn’t mean that they don’t deserve the best of everything we have to offer.

That nurse, by drawing to students’ attention the equal needs of vulnerable and disadvantaged patients, underlined the professional value of the importance of developing relationships with all patients and focusing on each patient’s needs. She attempted, in a teaching role, to assist students to find ways to relate to patients’ humanity and need for caring. These nurses believed that an important aspect of the caring relationship with patients is respect for that individual as a person.

Two nurses discussed their own struggles in working to respect each patient equally, notwithstanding different patient circumstances. Participant 3 described the challenge she experienced when patients on the medical-surgical unit showed patterns of drug addiction: “Do you withhold? I never have, but I have seen people kind of turn into
the role of a mother and, ‘No, you’re not having any more. That’s it.’ Or else they’ll play games with the amounts they’re getting.” Avoiding the interpersonal process of labelling and then disadvantaging particular patients was a key value that Participant 3 expressed as she worked to focus on the health care priorities for the patient in the current situation without becoming embroiled in disrespectful power strategies.

Two other participants described their own conscious struggle to empathize with each patient, indicating situations in which treating patients equally might be especially difficult. This aspect of caring could be expressed as the tension between the need to provide equally high-quality care to all patients and the difficulty nurses can experience in caring for patients whom they do not particularly “care for,” as in “like” or “hold in high regard.”.

The frankness with which these nurses discussed this issue spoke to the reflective nature of their nursing practice. For example, Participant 2 provided insight into the way in which she reflected on and worked through her perceived prejudice:

I have to work really hard on being judgemental with different cultures of people . . . . you don’t treat anybody any differently. You do the very best that you can, and you try to make them as comfortable as possible and treat them as equals.

This participant’s reflection on how one ensured that each patient received an equal standard of nursing care showed that this reflection is an ongoing process as nurses develop relationships with individual patients. Consciously working to ensure the equal and fair treatment of each patient was an ongoing process for these nurses.

The foregoing discussion by these nurses exemplified the value placed on caring and empathy, as well as the struggle to care for others whom they did not like or feel an affinity for. These nurses’ descriptions contained evidence of the role of caring and empathy in the relationships that these nurses developed with their patients. While
acknowledging that members of the nursing profession view caring as a fundamental value of nursing as a profession, some researchers have discouraged the use of that concept as the exclusive basis for the moral stance of nursing. Crigger (1997) pointed out the fragility of caring as the basis for ethics, as in her view, “partiality or favoritism” (p. 219) often formed an unstated basis of an ethic of care. The nurses who participated in this study discussed frankly and honestly the struggle that they experienced in fulfilling their value of providing equal levels of care to all patients, thereby demonstrating the inadequacy of the nursing concept of caring as a sole driving force in some instances. Rather, these nurses’ discourses reflected values such as equity and fairness, and a moral stance of being “for” patients, notwithstanding any perceived merit or value of the patients.

**Nurses as Patient Advocates**

Six participants explicitly used the language of the nurse as patient advocate in their discussion of the nurses’ expression of caring for patients: “So I suppose, you know, you advocate on behalf of the patient and the family if you’re sure that you know that that family is okay with what you’re doing” [Participant 1]; “[E]ven if it wasn’t a severe outcome, I felt if the patient can’t speak on their behalf, then I would . . . . I’ve always been a strong patient advocate” [Participant 3]; “[Y]ou have to advocate for yourself and for your patient” [Participant 10]; “Would I be an advocate when I ignore people who are in pain?” [Participant 4]; “[M]ost of the things that we’ve talked about are my sense of the importance of my role as an advocate, the conviction that people need to be treated in a way that I consider fair and compassionate” [Participant 8]. Participant 5 linked a personal experience with her development as an advocate for patients:
[T]hat feeling, that strong feeling, comes personally from my experience I had with my dad, and that has carried over... an advocate for the patient, I think in a good way, because I’m very aware of the patients and what they’re going through.

Each of these nurses used the language of patient advocacy to describe their actions on behalf of their patients. Even though nurse practice legislation in many jurisdictions supports nurses’ advocacy role (CNO, 2002; Mallik, 1997; Schwartz, 2002), some researchers have pointed out that the power imbalances in hospital nurse-physician relationships continue to stand in the way of nurses’ efforts within the advocate role (Bull & FitzGerald, 2004; Mallik, 1997, 1998; Martin, 1998; Snowball, 1996).

The participants described situations in which they had considered intervening on behalf of patients to ensure that health care providers addressed the patients’ needs and best interests. Some nurses used terms such as empathy or compassion in their discussion of their focus on the needs of the patients. Six of the participants explicitly used the term advocate, but others recounted situations in which the nurse advocacy role was evident. Engaging in and maintaining respectful, caring relationships and representing the patients’ wishes and needs to others constituted key aspects of nursing relational practice for these nurses.

Power Inequality Affecting Nurse-Physician Professional Relationships

The nurses often described themselves as working to bring about the best outcomes for patients in a nurse-physician relationship characterized by a very great power differential. Many of the preceding and subsequent examples involved the nurses stating preferred outcomes to ethical problems but being unable to bring about those outcomes because of the nurses’ subordinate, relatively powerless role within the hierarchical organization. Nevertheless, a number of the nurses were able to influence
outcomes, sometimes quite dramatically, as they worked within relationships with powerful others, including physicians. The nurses’ descriptions of themselves in relation to other caregivers that are presented later in this chapter include the nurses’ comments on the approaches that they preferred to take in relation to physicians as well as other care providers. However, each of the subsequent chapters discusses the specific relationship between nurses and physicians.

Nurses’ Interactions and Potential Conflict With Patients’ Families

Nurses’ Concern for Family Members

The nurses discussed caring for patients within the context of their families, in that family visitors constituted an important relational influence on patients and patients’ care. This influence, although important to and supported by the nurses, was also a focus of conflict for the nurses at times: Even though care of the families was very important, care of patients tended to receive higher priority because the patients were the main focus of the nurses’ care.

These nurses’ caring values and actions were not limited to patients. All of the nurses expressed concern for and caring attitudes toward their patients’ family members. Participant 1, reflecting on her own experience as a family member of a patient in the past, reflected on the needs of nurses to recognize the needs of the families and to support them in making the best decisions possible:

You really know in your heart what you want to say to them, but sometimes, you kind of have to let them come to . . . whatever they’re comfortable with. As well, you can’t tell someone what to do . . . it’s not your place.

Participant 1 went on to describe her advocacy for particular symptom relief for a patient, recognizing that the family also would benefit from the reduced suffering of their
family member. Participant 1 described how providing the patient with medication for excessive secretions might not only increase the patient’s comfort but also provide the family with a different or better memory of their loved one’s final hours. She indicated that the physician sometimes did not understand why she might ask for specific orders:

I’ve said to docs, “This person is not doing well. There’s lots of fluid on the board. Can we please give them some scopolamine or something to dry up the secretions”? and they say, “What purpose would that do?”

Participant 1 described how she explained to the physician that the symptom relief, not harming, but perhaps not helping the patient, would be helpful to the patient’s family members. She commented, “And you just say, ‘Well . . . it’s for the family’s sake. They’re in there all the time. [The patient is] really, really gurgly.’” Appealing to the physician’s respect for and altruistic motivation to help the family as well as the patient, Participant 1 would ask the doctor, “Isn’t there something that we can give [the patient] to calm that down?” She expressed the importance of this for the patient’s family, stating, “What a horrible way to remember your loved one, gasping and having their last breath, and living their last few hours like that.” That nurse recognized the family members’ distress at seeing their loved one struggling to breathe, identified a medical approach that would increase the comfort of the patient and the family members, and advocated that solution to the physician. Challenged by the physician that the approach would not improve the patient’s overall condition, Participant 1 explained that the treatment would reduce the patient’s symptoms and would be comforting to the family.

Other nurses expressed compassion for family members distressed by the suffering of their loved ones. For example, Participant 5 described a situation in which the patient’s current wife refused to discontinue his treatment, despite his continued deterioration over
many months. The impact of this situation on the patient’s children was cause for concern for this nurse, who noted, “And the son and daughter would come in, and they were just devastated when they saw their father like that, because he was just . . . he looked like something from a prison camp by the end.” In that situation, the nurse expressed concern for the patient and observed the suffering of the patient’s children as they watched, helplessly, while their father wasted away over months. The concern of Participant 5 for her nonresponsive patient focused on his comfort and dignity, and by drawing attention to his children’s anguish, the nurse focused on another relationship of concern to the nurse.

Participant 7 witnessed a medical misadventure that resulted in the patient being without oxygen for 8 minutes and therefore suffering brain damage. Participant 7 focused not only on the patient but also on the devastating result of this event on the patient’s wife: “Well, the ethical part for me is, his wife – this was about 5 days ago – and his wife still does not understand completely the ramifications of what happened or that we, in my opinion, failed her.” Similar to Participant 5, Participant 7 had a relationship with the patient’s family member, in this case, the wife, and expressed concern for this family member as the patient’s condition deteriorated suddenly and rapidly. Participant 7 experienced an ethical problem related to the wife’s right to know that her husband’s condition had deteriorated because of a medical error.

Another nurse recounted a situation in which a patient had decided not to return to artificial ventilation, with the result that the patient was dying. Participant 9 emphasized care and concern for the patient’s mother as a focus of her ethical concern:

Well, hearing the mom’s anguish, you know? I thought, “Oh, my gosh, she loves her daughter like crazy” . . . . you’ve got to look at what’s to the benefit to the patient, and we needed to make her comfortable.
Struggling with the need to give medication to alleviate the patient’s suffering, Participant 9 questioned whether she acted ethically in reassuring the mother that the medication had not killed her daughter when the nurse was unsure of the accuracy of that statement, and she continued to reflect on that situation several years later. All of these nurses described their relational concern for patients’ family members.

The nurses spoke of physicians sometimes asking family members to make decisions that could be extremely difficult. Participant 8 identified as an ethical problem the way in which families often were asked to make decisions around discontinuation of their family members’ treatment. Participant 8 believed that these decisions were not actually the families’ decisions to make, especially in circumstances when the patients were not going to recover. Asking families to make decisions to end treatment in such situations left those family members with an enormous sense of responsibility: “On more than one occasion, there’ve been conversations with families around withdrawal of care when the case is seen as medically futile.” This nurse’s sensitivity to family members’ burden of end-of-life decision making led her to alleviate this pressure whenever possible.

In a somewhat similar situation, Participant 10 described how she attempted to help family members who experienced difficulty related to choices in treatment for their loved ones. Participant 10 tried to find ways to support the family and to help to alleviate those families of doubt and guilt once they had made choices on behalf of family members:

[F]amilies have a big struggle, they have an immense struggle, trying to decide what is right, because they want to do the right thing. They want to do what’s best for their family member if the family member is unable to make that choice.
Both of these nurses focused on the needs of the patient but also the concerns of the family members making decisions on behalf of their loved ones. The nurses engaged relationally not only with their patients but also with the patients’ family members. In the different ways elucidated, the nurses expressed respect, care, and concern for the families of their patients.

*Nurses’ Potential Ethical Conflicts With Patients’ Families*

Several nurses described situations in which they viewed patients’ best interests to be in conflict with family members’ wishes. In fact, many of the ethical dilemmas that the nurses experienced had to do with their perceptions that the family members acted or wished to act in ways that were contrary to the patients’ expressed wishes or the patients’ best interests. In one case, a nurse worked with a patient whose son refused to allow the patient to die, a wish that the patient clearly had. To prevent the patient from removing his tracheostomy tube, the son insisted that his father have wrist restraints. Participant 4 explained, “[Y]ou knew what he wanted, and you knew that he knew what he wanted, so it was difficult to help him along, because there was another block there. There was this family member that was balking.” For Participant 4, seeing the patient’s wishes ignored by a son whose motivation was questionable was particularly difficult. Being required to support that son’s directives in violation of the patient’s wishes undermined not only the nurse’s ability to act in the best interests of the patient but also the nurse’s relationship with the patient. The nurse’s awareness of the previous father-son conflict, although explaining the son’s motivation, may have added to the sense of frustration.

Another family member contributed to a decision to end rather than prolong a patient’s life in a situation that would not normally involve such a decision. The physician
and the patient’s sister agreed to withdraw treatment, although the patient’s clinical situation did not seem to invite such a decision. The patient had serious fractures and respiratory problems resulting in probable disability, but no neurological injury. The basis for the decision to withdraw treatment was a conversation that the patient had had with a family member some time before, in which he indicated that he would not want to be disabled. Participant 7 believed that neither the patient’s current wishes nor his best interests were considered by the physician and family as they made the decision to let him die:

His sister said that he absolutely told her without question . . . “I would never agree to have rehabilitation. I would just, I would withdraw,” but people say those kinds of things all the time, but is that really what they mean . . . as circumstances change?

Participant 7 continued to struggle with the way in which this family member’s opinion influenced the physician’s decision, in the absence of the patient’s current view, to end the patient’s life. Participant 7 believed that this patient had been devalued in some way because of his drug and alcohol abuse. The nurse continued to be concerned that the physician’s engagement with the patient had occurred only through another family member, and Participant 7 continued to be sensitive to the possible disrespect for the patient related to his substance abuse.

Participant 10 described ways in which family members could unduly influence a patient’s situations against what the nurse viewed as the patient’s best interests:

You can see it from the patient’s point of view. You can see it from the family’s point of view, but we tend to side on the patient’s side, that they’ve had enough, they’ve done enough, and “just let me go, family.”

Participant 10 described her knowledge of the patient’s perspective, gained through the relationship that she had developed with the patient and underlining her focus
on the patient’s needs rather than those of the family, as well as her patient advocacy role, factors directing her interactions with family members. Participant 10 advocated for patients by working in relationships with families to help them put their own needs aside and to recognize the patients’ viewpoints.

Participant 9 described her intervention with a patient’s daughter who had refused to notify her father that his wife was a patient in hospital:

So I don’t know what part of me that is, but the daughter was able to talk with me and communicate with me, and in the end, it was the daughter who phoned him. I didn’t even have to do it. She did it.

By engaging with the patient, Participant 9 believed that the patient had a right to have her estranged husband aware of her serious illness; she engaged in a relationship with the patient’s daughter to open relational space in order to discuss the problem. She was able to resolve the situation by working respectfully with the patient’s daughter and supporting the family member in making the phone call.

The nurses in this study, although focusing on the needs of family members as well as those of patients, nonetheless saw patients’ needs as paramount, and in some instances, they developed approaches to try to reconcile the needs of patients with the wishes of family members. Although the nurses’ primary relationship was with patients, they also developed important relationships with family members. In some particularly difficult situations, family members’ interventions led to long and drawn out deaths for their loved ones or, in one instance, an unexpected decision to discontinue treatment. Nurses in those situations found themselves struggling as they attempted to respect family members’ decisions that seemed not to be in the best interests of the patients. A number of nurses engaged in interpersonal approaches to reconcile patient and family perspectives in the
interests of the patients, underlining the strong social and interpersonal context of their ethical interventions.

**Importance of Other Health Care Providers to Nurses’ Ethical Concerns**

*Protecting Other Health Care Providers*

All of the participants, although expressing concern for their patients and their patients’ families, also described ways in which they showed caring concern for their coworkers. Six made clear statements about a preference to avoid harm to coworkers: “I wouldn’t want to put another professional in a bad light” [Participant 1]; “I don’t want to hurt anybody. I don’t want to affect anybody’s family life or their personal life” [Participant 3]; “I really don’t want to cause anyone grief” [Participant 7]; “I don’t like to make people uncomfortable” [Participant 8]. Two of the nurses spoke of protecting the feelings of other health care workers: “With both [nurses and physicians], it’s something that you have to learn how to handle without hurting their feelings” [Participant 3]; “I wouldn’t want to be confrontational about it because I know how I feel when somebody is confrontational with me; it’s a scary feeling when you think that somebody is questioning how you act” [Participant 5]. All of these participants emphasized that preventing harm to others and to the participants’ relationships with others was valued significantly.

*A Culture of Noninterference*

Other participants reflected on the need to weigh strengths and weaknesses of coworkers instead of simply focusing on the negative. As Participant 6 said about a difficult coworker, “Yes . . . it’s one of the hard line nurses . . . you have to remember that you have to work with everybody.” In another example, Participant 2 differentiated between situations in which she would report a colleague for taking medications
belonging to the hospital and other situations in which, having weighed the situation, she decided not to make a report: “I turn a blind eye if it’s not narcotics, I have to admit. If it’s narcotics, I think that’s illegal.” Participant 2, while deploring any theft from the hospital, stated that in deciding whether or not to intervene, she would differentiate between theft of narcotics and theft of nonnarcotic drugs in determining whether she would report a colleague. In both of these instances, the nurses considered the magnitude of the other nurse’s ethical lapse before acting in relation to a coworker’s problematic behaviour.

Nursing Ethics and Mentoring Responsibilities

Three participants discussed situations in which they were required to intervene on behalf of junior colleagues, working to support and mentor younger nurses. Participant 1 pointed out how important it was to ensure that less experienced colleagues provided safe and effective care. Participant 4 discussed the importance of mentorship during the period when junior colleagues acquired advanced nursing knowledge in the intensive care unit (ICU), stating, “But it’s not basic stuff. It’s sort of above that, so maybe the mentorship needs to be there for a longer time – and a lot of them don’t have it for a longer time.”

Participant 10 discussed the need for improved mentorship, noting, “You don’t always have that mentoring, but I think that is something they need to have. That mentoring, I think, is very important and probably something that could be done better.” Participant 10 had worked in the same area for many years. She described ways in which senior nurses by mentoring new staff could directly influence the culture and interpersonal tone of the nursing unit. It was her view that both the mentoring and the interpersonal outcomes could be threatened by increased patient acuity in which patients’ needs for
resources increased, thereby decreasing the sufficiency of the same staffing level.

Participant 10 discussed the need for newer nurses to learn to advocate for themselves:

I think nursing thinks that “I should be able to do this, and if I can’t do it, then there’s something wrong with me,” and so I tried to say, “No, there’s nothing wrong with you”. . . . It’s the acuity of the patients that we get in now.

Participant 10 recognized the less experienced colleagues’ inability to identify staffing and patient acuity levels as the origin of problems with safely completing patient care, so Participant 10 acted to assist those colleagues to recognize the problem as staffing levels in the care context and not the less experienced nurses’ disorganization.

Participant 1 described a sensitive way to help junior colleagues. She gave the example of

A new, inexperienced person or a person that is just not handling it well as a staff member . . . and the family is beside themselves . . . . Just kind of be like the mentor. Just kind of be like the shoulder there for the staff, as well as the family.

Participant 1 expressed caution at intervening unless absolutely necessary and identified a gradual approach to assessing the situation and carefully intervening. In that way, the needs of the patient and the family members would be met, and the relationship between the nurse colleague and the patient’s family would be preserved, as well as the coworker relationship between the nurses. All of the nurses who provided these examples were willing to develop relationships with colleagues that involved teaching, supporting, and mentoring newer colleagues, as well as avoiding criticism or intervention in other nurses’ care unless it was necessary.

The nurses were concerned with avoiding harm to others; they valued maintaining relationships with others, including nursing colleagues and physicians, protecting the feelings of others, and educating and mentoring newer nurses. However, a number of
nurses experienced tension between their concern for patients’ best interests and their wish to avoid harm to other health care providers. As one participant indicated, the value of protecting coworkers was sometimes in conflict with other values, including adhering to the rule of law, as in situations involving nurses stealing narcotics, or the best interests and needs of patients. These findings are important in providing further evidence of the intensely social context in which the nurses worked to resolve ethical problems. Later chapters discuss these issues further.

Conclusion

The results shed light on the backgrounds of the participants, as well as how those backgrounds contributed to their professional values and their ability to engage in ethical problem solving. The participants did not clearly articulate the impact of their personal backgrounds on their ethical actions. Only 4 nurses described aspects of their backgrounds or upbringing as influencing their ethical actions. In addition, 3 nurses described personal experiences with family members’ illnesses as having an impact on their subsequent ethical actions. Four nurses discussed their religious values as influencing their ethical values. Seven participants indicated that some aspect of their personal backgrounds or beliefs had had an impact on the ethical perspectives that they brought to their nursing practice. It is only possible to draw the most general conclusions from the results in this area. On the other hand, each of the nurses discussed, briefly or at length, the role of their nursing experience in the development of their ethical views, their clinical knowledge, competence, and confidence. As with samples from previous studies, the participants in this study retained and reflected on memories of ethically problematic situations that had occurred years and sometimes decades before (Woods, 1999).
Although clinical experience was important to these nurses’ development of ethical values, decisions, and actions, only 2 participants specifically mentioned ethics education as having an impact on their recognition or resolution of ethical problems. Principle-based ethics education became the norm in the late 1970s and early 1980s; therefore, some of the participants would not have studied ethical theories, principles or decision-making models. The results showed that all of the nurses expressed concern for the patients and bringing about the best outcomes for the patients, a result that was consistent with other studies (Erlen & Sereika, 1997; Fry et al., 2002; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Wurzbach, 1999).

All of the participants expressed concern for the family members of their patients. At the same time, a number of nurses described situations in which patient and family interests seemed to be in conflict. The nurses also stated their wish to avoid harm to other health care providers and to work well with others. However, as mentioned previously, the nurses described conflicts between the patients’ best interest and the behaviours of other care providers.

In conclusion, the nurses expressed concern for their patients and their patients’ best interests; they indicated that their efforts included engaging with patients around their wishes and interests. Many used the language of advocacy and/or empathy to describe that concern. The nurses also demonstrated a high level of respect and concern for patients’ families and other health care providers; at the same time, conflict between patients’ best interests and concern for family members or other care providers constituted sources of ethical tensions and problems for the nurses. In fact, the nurses’ descriptions of these complex interpersonal contexts underlined the deeply social nature of nurses’ ethical
decision making. A minority of the nurses described personal experiences, personal backgrounds, and/or religious beliefs as contributing to their ethical values, although it is difficult to draw further conclusions. All of the nurses cited past nursing experience as being very important in the development and expression of their ethical values. Only 2 nurses discussed ethics education as being important in the development of their ethical values or approaches to ethical problems.
CHAPTER 5: ETHICAL PROBLEMS DESCRIBED BY THE PARTICIPANTS

The participants from the two organizations identified a range of ethical problems related to the care that patients received. All of the nurses provided examples of ethical problems that were resolved as well as those that were not. This chapter presents the ethical problems identified by the participants. Included is a discussion of the nurses’ relationships with patients and the relationship(s) out of which ethical problems arose. The discussion arranges these concerns in parallel with the relationship sequence in the conceptual framework, that is, the nurses’ relationships with physicians, patients’ families, and coworkers, in order to illustrate the importance of each type of relationship in greater depth. The discussion shows that the ethical problems occurred within a layered relational context in terms of power relationships and duration of the relationships. What is revealed is a social context within which the nurses’ ethical decision making was situated. In addition to those relational areas, the discussion focuses on the organizational context that comprised an important aspect of the ethical problems and the importance of the organizational context.

In discussing each type of ethical problem, this chapter presents the participants’ descriptions of their ethical problems, their actions, and their guiding values and beliefs. It considers each type of ethical problem from a relational ethics perspective, considering the concepts of relational engagement, embodiment, mutual respect, uncertainty, and creation of ethical environments.

This discussion presents the nurses’ ethical problems, arranged according to three areas of focus. The nurses’ ethical problems focused on physicians’ behaviours, including
decisions made by physicians or actions of physicians that the nurses believed to be against the interests of the patients. Ethical problems also focused on decisions of family members that the nurses believed to be in the interests of the family members rather than the patients. Finally, ethical problems focused on decisions or actions of coworkers that presented some risk to patients, all occurring within the nurses’ professional and employment circumstances within the hospital organization. The nurses in both institutions raised all of these types of ethical concerns; although the details of the dilemmas and concerns varied somewhat from one organization to the other, their similarity in essentials was remarkable.

**Ethical Problems Involving Physicians**

Interactions between nurses and physicians occur in an historical context of differential power. The work setting reinforces societal norms privileging physician power in numerous ways, and nurses have learned to be deferential toward physicians and to avoid questioning physicians’ actions, behaviours, and decisions. The nurses in this study who decided to challenge physicians often did so in an atmosphere of interpersonal uncertainty, in which the outcome for the nurses could have been quite negative, notwithstanding the accuracy or correctness of the nurses’ perceptions, decisions, or actions. The negative outcomes could have included verbal abuse by the physicians; criticism by the physicians and/or others, including nurse managers and colleagues; potential of feeling labelled as a troublemaker; and, ultimately, dismissal or voluntary transfer away from the clinical area.

Although not every occasion of the nurses intervening with physicians resulted in negative outcomes, the ambiguity around the outcomes of these interactions caused the
nurses to think very carefully before confronting or challenging physicians; nonetheless, as is shown in this chapter, some nurses incurred significant risk to themselves by intervening with physicians when patients’ needs warranted such action. All of the participants discussed problems in relationships with some physicians that represented a range of problematic communication and behaviours that could have interfered with valuable exploration and resolution of ethical problems surrounding patient care. These nurse-physician relationships constituted an important layer of the nurses’ ethical problem-solving experience, a layer involving a significant power differential as well as shared responsibilities related to patients and sometimes patients’ families. These relationships also included coworkers and the organizational culture, expectations, and policies.

This chapter includes a section focusing on the importance of nurse-physician communication to nurses’ ethical problem solving. It is important to understand the often difficult, tense, or abusive communication of physicians that can form an important context in which nurses try to resolve ethical problems. From a relational ethics perspective, the refusal of some physicians to interact with nurses in a mutually respectful way closes relational space in general and relational space in particular, in which physicians and nurses, as well as patients and others, could come together to consider and possibly resolve ethical problems. Although several of the nurses described good relationships with some physicians, all of them described such problematic physician behaviours as disinterest, casual rudeness, and verbal and outright harassment.
Problematic Physician Communication

Prior to discussing actual ethical problems recounted by the participants, it is important to understand the context in which these nurses experienced those concerns, a context in which the nurses’ relationships with physicians were critically important in creating relational space in which to consider ethical problems and bring about the best outcomes for patients.

Several of the participants pointed out that their relationships with many physicians were very positive and functional. Participant 5 stated:

I think in [current unit], the staff men that work respect the nurses, and . . . if we feel that there is a problem or an issue with the patient, that they will listen to us and they respect what we have to say, and that was a good feeling, because it sort of gives you a little bit of feeling of empowerment that you’re respected, that your opinion and your experience and your work with the patient is being respected by the physician.

This nurse’s comments underlined the importance of good communication between physicians and nurses for effective patient-centred teamwork; difficulty in maintaining effective communication between nurses and physicians could jeopardize the patients’ care. Given the pervasiveness of problematic communication, some nurses felt the need to emphasize that there were exceptions. Participant 9 described two specific physicians in glowing terms: “I’d even say Dr. ____ and Dr. ____ . . . are . . . very approachable when you feel like you can go up to them and say, ‘I’m not feeling right about this. Something’s not feeling good here.’” Participant 9 went on to describe the respectful responsiveness of those two physicians, noting that “and they’ll either make you feel better or say, ‘Hey, you know what? You’re right. We’ve got to do something about that.’” Relationships conducive to good communication were, to this nurse as well as others, directly related to good patient care and better patient outcomes, making it
more likely that nurses would bring forward ethical concerns and work with physicians to resolve them.

It is striking, however, that all of the nurses described problematic communication with physicians that included simple disinterest, rudeness, and harassment. Participant 6, who had pointed out that some physicians were good to work with, qualified this assertion with a comment about expected physician rudeness and the deference expected from the nurse:

I say, “Good morning” . . . No answer . . . you’re telling them about the patient . . . They ignore you totally and completely. They look at the chart and walk away . . . You have to still show them respect, or you won’t get any response from them.

Participant 6 struggled to maintain civil and professional communication with doctors, despite the physicians’ simple rudeness and disrespectful behaviour. Participant 10, reflecting on a career that had spanned several decades, pointed out that even though physicians’ consultations with nurses had improved over time, nurses were still expected to tolerate rude and abusive verbal behaviour from physicians: “I find more communication . . . than when I first started out, much more. And some of them even ask your opinion now and then, and that kind of thing.” However, Participant 10 qualified her suggestion that physician-nurse relationships had improved over the decades:

But we do get other doctors in there . . . you know, you do get some that are really rude, and you just hang up the phone [laughs] – just disconnect it. No, you can’t do that, of course, but it’s what you want to do.

Tolerance of such unacceptable behaviours would be less likely from another professional in another employment setting or in the hospital setting from a nonphysician employee, but such tolerance has long been an expectation of nurses in relation to physicians’ negative communication. Given the pervasive risk of encountering rude
communication and verbal abuse by some physicians, the nurses found themselves expending extensive time and effort considering when and how to approach doctors to resolve ethical problems. Through experience, the nurses were able to predict which physicians they could expect effective communication from, as well as those with whom they could expect to have difficult interactions.

Participant 5, discussing an issue of great concern, made two seemingly contradictory comments regarding seeking interaction with physicians: “I would not in the slightest have any fear. I would not feel that it would be a risk for me to speak to a physician, whether it’s a neurosurgeon or a staff person or resident.” Participant 5 avoided certain types of interaction with one particular physician, anticipating verbal abuse as a response to any confrontation: “I would never question anything that he would do for his patients . . . . because he would probably rip me up one side and down the other and not even think a second about it.”

Participant 5 selectively avoided confrontation with that particular physician, at the same time recognizing that other nurses were able to challenge him without negative repercussions, suggesting that those other nurses had developed specific interactional skills through greater experience with the doctor.

Participant 1, who was more comfortable intervening with physicians on patients’ behalf, expressed confidence in her clinical knowledge and experience but acknowledged that physicians might respond differently to less experienced nurses:

[I]f they know you, recognize your voice, and if they’ve seen you around . . . . there is some sort of comfortable feeling with people that have been around the block a little bit and how they communicate with the docs might be a little different.
Although Participant 1 described the positive effects of nurse experience on physician response, Participant 2, another very experienced nurse, described how the less experienced nurses’ fear of verbal abuse from physicians could negatively affect the patient’s care: “And if it’s an inexperience nurse, maybe she’ll say, ‘Oh, I’m scared.’ I’ve seen it . . . Yeah, there is a risk to the patient, a risk to the hospital.”

Participant 2 described the importance of nurse-physician communication to patients’ health care, with poor communication creating risks to patients, but also underlined the importance to nurses’ self-esteem of not having to experience verbal abuse. Participant 2 made further comments related to the impact of physicians’ abusive communication on nurses’ willingness to telephone physicians to convey patient information: “They are scared to call, because they are afraid of being yelled at, absolutely.”

Participant 2 went on to describe organizational supports to nurses experiencing abusive, threatening, or other negative communication from particular physicians: “[Nurse manager] . . . says, ‘Don’t you ever not call and report an abnormal that could potentially be life threatening because you’re afraid of Dr. _____. If that doctor yells at you, you’re to let me know immediately.’ They’ve got zero tolerance for it.”

Participant 2 drew attention to a zero tolerance policy, a relatively new hospital policy designed to curtail abusive physician behaviour, in which the nursing and medical hierarchy would intervene after the fact should any physician engage in hostile, threatening, or abusive communication toward a nurse. It is unclear whether the physicians faced any negative sanctions following their abusive behaviours. Both of these experienced nurses indicated that they had found ways over the years of improving the
functionality of their communication with physicians. Yet, the negative repercussions of problematic or abusive interactions on the part of doctors caused at least one of the two employing organizations to establish a policy that negatively sanctioned physicians who engaged in such behaviours. Although this response was laudable, it was limited only the most offensive types of behaviour, and it is unclear whether such a policy would actually help to create an environment of mutual respect or to help open relational space for health professionals to focus on solving problems associated with patients’ care.

Some very experienced nurses recounted how they had developed a greater confidence in approaching physicians as their careers had developed. They had become more comfortable using challenging and confronting communication, and otherwise questioning physicians’ approaches to patients, than they had been earlier in their careers. For example, Participant 1 pointed out how she drew physicians’ attention to the ultimate patient benefit of specific tests and treatments versus the risk of excessive testing or overtreatment: “I take risks a lot with the doctors. I take risks by basically confronting them. It’s like, ‘Why are we doing this? What purpose does this have? Do we really need to continue it?’ ”

Participant 1 described how she questioned doctors’ orders that were not in a patient’s best interests, focusing the discussion on the needs of the patient: “I really put them on the spot, like ‘What is the benefit of doing this? It’s not to prolong life. It’s not a comfort measure, so why are we doing it?’” As a result of such discussion, Participant 1 often found that the physician would engage with her in considering what should be the focus of the orders:
And most of the time, they kind of back off and start slowly getting rid of half the blood work and half of the vitals that they might’ve wanted . . . you generally have to put the idea in their head. They don’t often come up with it themselves.

This nurse’s extensive clinical experience and knowledge of the patient, the nursing unit, the physicians, and the organizational context were helpful to her in experiencing greater mutual respect with the physicians. She was able to open relational space with physicians and focus the nurse-physician discussion on the purpose of particular tests or treatments in terms of the best interests of patients. Participant 1 had developed an approach over time and had gained the respect of the physicians in working to accomplish patient-focused aims. The nurse’s background of experience contributed not only clinical knowledge and confidence but also a way of communicating with physicians.

Regarding physicians, Participant 1 also commented, “The younger ones sometimes are better . . . more observant of what we say as nurses . . . they’ve suddenly discovered that nurses actually have a role here with the patient’s care because we’re at the bedside 24/7.” This very experienced nurse found that in general, younger physicians were more likely to respect the perspectives of the nurses. She described herself as being able to approach physicians, ask fundamental questions about the purpose of specific orders in terms of patients’ best interests, and press them to alter those orders. While acknowledging that this was difficult and sometimes frustrating, this nurse described herself as persisting in these actions when necessary in terms of patients’ care needs, recognizing the relational dynamics that physicians may have experienced with other nurses. As documented in another study, this nurse would compromise if possible, protest by direct confrontation, and consider subverting orders if necessary (Woods, 1999).
On the continuum of nurse-physician relationships, Participant 2 described a constellation of extremely difficult, disruptive, abusive, and harassing behaviour. She spoke at length about the types of difficult interactions nurses experienced with physicians, and the very negative impact these had on nursing staff. Participant 2 described physicians whose behaviour was extremely problematic to the nursing staff:

[Medical specialist] . . . told [previous nurse manager] that he’d better get some girls on the floor that were slender and smart, because he wanted a good impression given to his patients when he tells his diabetics that they need to lose weight.

Participant 2 felt that the physician had directed the comment at herself and another nurse, so she complained to the chief of medical staff: “And Dr. [chief of medical staff] advised us that we could press charges against him. It was totally, totally wrong.” In this example, the nurse felt demeaned, harassed, and deeply offended by the physician’s remarks about her and other nurses’ physical appearances.

Participant 2 was describing a type of harassing behaviour normally prohibited in workplaces, a behaviour that can only reduce the likelihood of developing effective relationships. Indeed, given this physician’s stated disrespect for the nurses, it seems very unlikely that there would be any relational space in which this physician and the nurses could come together to focus on concerns related to patients. According to this nurse, the staff ignored that physician. Intervention by the nurse manager and the chief of medical staff constituted supportive behaviour toward the nurses in this situation, although there is no evidence of sanctions against the individual physician.

Participant 2 also reported other extremely disruptive physician behaviour; she recounted numerous examples of problematic interpersonal approaches on the part of a different doctor. In that example, Participant 2 had just returned to work after losing her
mother and arrived at work to find that the nurse on the previous shift had left aspects of patient care undone. The physician berated the nurse for the lapses in the other nurse’s care:

[H]e started yelling at me, and I said, “Don’t you yell at me” . . . and he goes, “Who in the hell are you? You make mistakes, I’ll god-damned well yell at you,” and he started swearing in front of the patients. I was embarrassed, and he was saying the “f” word.

Participant 2 recounted how she, other nurses, and the nursing supervisor intervened to the chief of the physician’s specialty, who “went over to the OR, called him, and talked to him.” Participant 2 expressed concern that patients could “lose their faith in their doctor when they hear the doctor yelling at us,” contrasting the physician’s behaviour with patients and with nurses:

[T]he doctors come in, and they’re so professional and kind, and “How are you today? You look great. The surgery was a success,” and then in the next breath they’re calling you a loser. So what is that patient thinking of the doctor? Have they lost any respect for that doctor?

Participant 2 expressed concern that patients could be harmed by their loss of confidence in hospital staff and by the disruptive influence of such hostile communication: “I think that they do lose respect for both the nurse and the doctor. And then, they’re not getting that emotional stability that they need to heal from their surgery.”

This extremely hostile and abusive communication, from the perspective of that nurse, not only undermined patients’ confidence in the health care providers but also increased the risk that the nurses would fail to contact such physicians in a timely fashion about changes in patients’ situations, contact that was necessary for effective, safe patient care. Nurses who were concerned for their patients and needing to converse with the
physician worked to overcome the risk of encountering difficult or abusive communication from physicians. These comments clearly linked the issue of physicians’ harassing and abusive communication to reduced quality of patient care. The zero tolerance policy instituted by one organization was, according to Participant 2, helpful in eliminating the impunity with which some physicians conducted these very negative forms of communication: Intervention by others in the organizational hierarchy in itself may have served as a sanction.

If nurses found themselves reluctant to approach such physicians about changes in patients’ conditions, it is easy to understand that they would have been even more hesitant to attempt to communicate with these doctors about ethical concerns. The disrespectful behaviour of these doctors prevented nurses from engaging with them in mutually respectful discussion about ethical problems related to the patients for whom they both had responsibility. These instances provided examples of the ways in which the nurses’ ethical decision making was socially situated.

The previous discussion was included specifically to present the participants’ views about their relationships with physicians. It was within the context of these relationships that the nurses worked to resolve ethical problems related to their patients. Many of these nurses provided positive examples of relationships characterized by good communication, mutual respect, and teamwork. However, most of the nurses described difficult relationships with some physicians, including rude, disrespectful, intimidating, and/or abusive behaviours on the part of some members of the medical staff. These behaviours interfered with the nurses’ willingness to engage in problem solving with these individual doctors; furthermore, disrespectful comments and behaviours on the part
of physicians seemed to create an interpersonal context antithetical to that required for engaging in discussion around ethical problems and resolving those concerns. Some of the nurses described tense and ambiguous interpersonal contexts that made it difficult for the nurse to assess the interpersonal and other risks involved in intervening with physicians. The study results indicated that the clinical nursing experience, including shared experiences with physicians, made a significant difference in how the nurses might approach difficult interactions with physicians.

**Ethical Problems Related to Physicians’ Decision Making in Patient Care**

Numerous issues arising in nurse-physician interactions can result in ethical problems for nurses. For example, differences of opinion can occur between nurses and physicians regarding patients’ best interests, patients’ right to choose, or the best course of action in a particular patient situation. Analysis of the ethical problems presented by the participants revealed evidence of the nurses “knowing” what should happen but being unable to bring about those results because of the power differential between the nurses and the physicians. That power differential could play out in each physician-nurse interaction, many of which became problematic. In such situations, nurses may experience a restricted freedom to act related to relational norms in which the nurses might avoid confrontation with powerful others such as physicians because of the fear of the negative sanctions that might result. The social context of interpersonal relationships can have a direct impact on nurses’ ethical problem solving.

Eight of the 10 participants described ethical problems related to differences between nurses and physicians regarding what should happen to the patients. The nurses experienced ethical problems when physicians overlooked essential aspects of patient
care, when physicians failed to offer the patients all options, when physicians ordered treatment that in the nurses’ opinions was excessive and potentially harmful to patients, or when physicians harmed patients by ignoring symptoms or failing to provide acceptable levels of care. These issues became ethically problematic for the nurses because they occurred within professional and organizational contexts in which the much more powerful physicians were the primary decision makers, supported by social and organizational norms, while historical, cultural, and relational barriers existed against the nurses intervening on behalf of patients. As described earlier, the specific problematic interpersonal approaches of some physicians communicated very clearly to nurses that they might experience significant conflict or even abuse should they challenge or confront physicians.

Within a context where the nurses sometimes viewed medical boundaries as carefully guarded, they sometimes used great delicacy in finding ways to bring about the necessary medical decisions and care. An example of this relational care involved a patient whose protracted wait for a tracheostomy was having a negative impact on her clinical condition. Participant 5 expressed elation when she was able to intervene effectively with the physician to have the tracheostomy accomplished. She noted that the ventilated patient had waited for more than 2 weeks for a tracheostomy, and she believed that the patient’s clinical and emotional situations were deteriorating because of the delay. Participant 5 carefully approached the physician: “Well, the physician that was in charge of . . . that patient came in that morning. And I said, ‘____[physician’s name], I need to have you come in here for a minute.’ He said, ‘What do you need?’ ” Through diplomatic and respectful confrontation, the nurse brought forward the patient’s need:
I said, “This lady has been here for 25 days, intubated. Two weeks she’s been on the list for a tracheostomy . . . . We can’t get her blood sugars under control. She has a huge sacral ulcer that we can’t get healed. She needs to have the tracheostomy.”

The physician’s response to Participant 5 was immediate:

He turned around, got on the phone, and that day, she had her trach. I was so happy. I thought, “Oh, my God. I got her her trach!” Like, it was such a good feeling when I came in and saw that she had her tracheostomy.

Having engaged with the physician around this oversight, the nurse’s persuasive arguments citing the urgency of the patient’s situation created the result she sought, bringing about a positive outcome for her patient without jeopardizing the relationship with the physician. The care with which this nurse arranged the interaction underlines the discomfort experienced by nurses confronting physicians regarding lapses in medical care. Recognizing the significant power differential, this nurse used diplomacy and maintained an aura of clinical objectivity around the decision in order to bring about the result for the patient without offending the physician. Nonetheless, the nurse was still elated at having brought about what should have been a straightforward decision.

A participant in this study whose decades-long career had spanned a period of change in practices related to informed consent discussed issues of patient choice. Participant 10 recalled a time when hospitals viewed physicians’ authority as sufficient for health care decisions, when patients and families had little expectation of receiving information or choices, and when nursing advice to patients and families was extremely risky. Participant 10 described a situation from several decades ago that had caused her an ethical problem. A patient and a family living at a great distance from the hospital felt pressured by an oncologist to consent to follow-up medical therapy for an inoperable cancer; the patient was clear that he preferred not to have any further treatment, but the
family experienced considerable conflict between their father’s wishes and the medical specialist’s directive. At a time when physicians carried out such discussions without any nursing input, and when and patient choice was not an expectation, Participant 10 decided to act:

I said to one of the sons, “You know, you can have the family and with your father decide not to have anything further done, you know. That also is an option,” because the patient was pretty adamant that he didn’t want anything done.

This nurse recounted that her advice was completely at odds with that of the oncologists at the cancer clinic: “The Cancer Clinic, on the other hand, were saying, ‘Well, yes, this has to be done.’

Participant 10 had acted decades previously when patients’ rights to informed consent were of less concern to the health care system than it is currently. She experienced great uncertainty regarding whether she would receive support or sanctions for acting. She reflected on how emphasis on informed consent increased the choices available to patients and families: “But the doctors, I find, nowadays give the patients and the families more options than they did before . . . . There wasn’t all of this informed consent like there is now.”

When asked if it had been risky for the nurse to intervene, as she had done in that case, Participant 10 indicated that it probably had been. This nurse pointed out the lack of emphasis on patients’ rights to informed consent at that time: “You didn’t have so many people backing you up at that point in time either.” This underlined the extent to which the nurse had stood alone in engaging with this patient and family, and in respecting their need to consider all available options as they worked through how best to help the father,
who had an inoperable cancer. By opening this relational space, the nurse was able to provide support to the patient and family as they decided how to proceed.

Decades ago, possible risks related to physician power, organizational norms, and licensing legislation all caused this nurse to believe that the situation was risky; it may have been for this reason that the nurse opened relational space with this patient and family but did not involve physicians or other health care providers. Twenty years later, on the other hand, clear legal, organizational, and professional guidelines ensuring patients’ informed consent, as well as shared values around patient choice, supported the nurse in ensuring that patients and families had adequate information and reduced the risk to the nurse in working toward this goal.

The theme of providing adequate information formed the basis for another nurse’s concern about a physician’s approach to patients’ families. In the view of Participant 8, the physician’s practice of asking families’ permission to withdraw treatment in situations where it was inevitable that the patient would die caused unnecessary anguish and guilt for family members, without benefiting anyone. Participant 8 said, “I’ve had times when I’ve talked to doctors about asking them to rephrase what they’re going to say.” She went on to explain to the physician that communication to the family could be quite misleading, burdening family members with the impression that their decision would be a “life or death” one, even though the patient’s grave prognosis dictated that death would come, no matter what the family decided. Participant 8 asked the physician to

Let the family know that this is something that is going to happen and that we want their participation with respect to how and when it’s going to happen, as opposed to asking them for permission for something that really is going to happen anyway.
Influencing the physician to reframe the discussion was this nurse’s goal, and having created the relational space in which the nurse and physician could discuss and alter the content of the physician’s communication, the ethical problem was resolved. Carefully assessing the context, engaging with the physician in a respectful way, using reflective interpersonal communication, opening relational space, and finding intellectual common ground were among the relationship-building approaches through which Participant 8 brought about a better outcome for the patient’s families. In this way, she was able to strengthen her relationships with physicians and families.

Participant 4 found that she was unable to intervene effectively when she observed patients receiving insufficient sedation prior to elective cardioversion procedures. A policy change had eliminated the requirement to have an anaesthetist available to provide analgesia for such treatment, resulting in a situation “where the physician doesn’t give enough analgesia to cardiovert . . . . so they’re not out . . . when they’re getting cardioverted,” with the result that the patients were harmed by experiencing unnecessary pain. Participant 4 acknowledged, “To me, that’s terrible.”

Participant 4 expressed frustration at the lack of physician response to the nurses’ expressions of concern, but she believed the ultimate decision to be outside her jurisdiction. She commented, “It is disturbing. It makes me sick . . . but then, as a nurse what can I do? I can bring it to the manager’s attention, you know? They [the physicians] rule.” Observing such inadequate medical care but believing that she could not intervene created an ethical problem for Participant 4, one that she felt powerless to resolve. She pointed out that in previous years, an anaesthetist had administered adequate effective analgesia; current patients, without an anaesthetist to administer their analgesia, not only
showed evidence of pain but also recalled the painful event afterward. Participant 4 believed that this patient suffering was unnecessary, and mentioned it to the physician: “Yes, we can just mention that it’s not enough, but I wouldn’t go any further than that, because . . . they only get angry with you. They’re the doctor, not you.” When asked what could happen were she to pursue the issue further, Participant 4 noted, “I think what can happen is that you become on bad terms with people, and that isn’t good for a working relationship.”

Participant 4 also believed that risking such a confrontation and possible breakdown in relationship would in fact not bring about the desired change. She noted, “The outcome really is the same, whether you say anything or not.” Anticipating that intervention would fail to change the problematic physician behaviour, that nurse decided not to press the issue and abandoned the attempt to resolve this ethical problem; patients continued to receive inadequate anaesthetic prior to the cardioversion, they continued to experience pain that the nurse believed to be unnecessary, and the nurse experienced moral distress.

In this instance, the nurse had no confidence in an ability to open adequate relational space for the nurse and physician to work together regarding her observation that patients were experiencing seemingly unnecessary pain. Previous attempts to discuss the issue had informed the nurse’s belief that she had no further practical options. Participant 4 recounted how she brought this issue to the attention of the physician without having any effect and then considered other alternatives: “[S]o how do you stop it? I don’t know, unless you report them . . . to the chief . . . to the College [of Physicians and Surgeons of Ontario], and do people really want to go that far?” Participant 4
reflected that the anaesthetic dosage was within the physician’s scope of practice and authority, not hers, so she decided not to intervene. Believing that any further action would simply escalate a negative relationship with the physician without bringing about the desired good for patients, this nurse decided not to act and continued to experience frustration.

Silence rather than action resulted in remorse for a nurse caring for a patient whose life a physician jeopardized through a failed attempt at intubation (insertion of a breathing tube into the breathing passage). This less-experienced nurse, Participant 7, was unable find a way to stop a physician from carrying out an intubation that the nurse believed he was unable to perform, thereby leaving the patient without oxygen for an extended period. Participant 7 had uneasily anticipated that the physician might have difficulty with the procedure:

The issue is that I didn’t trust the doctor, frankly . . . I asked him several times if he really wanted to intubate this person and, in fact, he went ahead and did it, and I didn’t think he was going to be able to and, in fact, he didn’t.

Participant 7 was unable to find a way to convey the concern to the physician in an effective way: “I didn’t feel comfortable at the time saying, “You know, doctor, I don’t think you can do this. Step aside and let someone else take over.” Participant 7 found it simply too risky to confront the physician: “You know, the big risk was saying to the doctor, ‘Get someone else to do this, because I don’t think you can.’ And I didn’t feel comfortable making that statement.” The result for Participant 7 of not being able to find a way to stop the physician was regret at avoiding the confrontation:

I really don’t want to cause anyone grief or . . . I just don’t want to disturb the status quo . . . It’s a confrontation . . . as much as I claim to not mind confrontation, I’m only so good at it, I guess, really.
A lack of privacy for such a conversation, as well as lack of time, also impeded the nurse’s action. The physician was unable to insert an endotracheal tube for breathing, within an acceptable period. The patient was without oxygen for a prolonged period, and the nurse consequently believed that the patient suffered brain damage as a result. Participant 7 expressed regret and possibly remorse at not having intervened to protect the patient’s safety: “Rather than risk displeasure or confrontation, I went along with what the doctor and the respiratory therapist felt was due process, I guess.”

Trust in one’s own knowledge of the situation, confidence to act, and the interpersonal skills to effectively intervene all seemed to be qualities that this nurse lacked in this instance, but which could develop following reflection on experiences such as this one. Other nurses, when discussing their increasing ease in overcoming reluctance to act, had spoken of previous negative experiences in which they had remained silent; those experiences had increased those nurses’ determination to act on ethical beliefs rather than experience regret and feel remorse for not having acted. One has the sense that this circumstance, with its dire result for the patient, constituted such a critical experience for this nurse.

From a relational perspective, the nurse struggled between maintaining a respectful approach to the physician and rapidly opening relational space in which to address the physician’s probable inadequacy to perform the skill. Uncertainty about the physician’s skill compounded this nurse’s difficulty in acting. Both of the aforementioned nurses avoided harming their relationships with individual doctors, but in the process, they abandoned attempts at intervention that would have kept the patients comfortable or
safe. The inadequacy of the nurse-physician relational dynamic contributed to harm to patients.

At times, the nurses mentioned being required to act assertively when patient safety was seemingly threatened. Participant 3 was concerned that a patient was going to die unless the physician, who had dismissed him as a “wimp,” attended to his symptoms:

I did ask several times . . . “please, please, please,” about this person, and I kept getting shut down, right? It was a new physician too, you know? So, I mean, they don’t know. They go with what they think, too . . . like, “Don’t tell me. I will tell you what to do.”

Later recognizing that the patient had the symptoms of a pulmonary embolism, a serious medical condition, the nurse asked the physician to order tests to confirm the diagnosis. The physician continued to dismiss the patient’s symptoms:

I wrote on his chart, “PE?” Well, the physician came back and he said, “When you write something like this on the progress notes, you’re forcing my hand to write, and I don’t appreciate that,” and I said, “Yeah, I know.”

Even though she recognized that her action had been risky, Participant 3 was gratified that this action had been effective in drawing the physician’s attention to the symptoms that the patient displayed: “So he wrote all the stuff for pulmonary emboli and sure enough, the guy had pulmonary emboli. He was put on a heparin drip and the situation resolved.” Participant 3 was not the patient’s assigned nurse and realized that the confrontational action had been risky because it was unexpected in a nurse: “I went beyond my boundaries. And in my opinion, I did the right thing because the outcome was good.” Significant personal risk to bring about a positive outcome for the patient seemed more important to this nurse than doing nothing, keeping herself safe, and risking jeopardy to the patient.
The nurse’s ethical problem in this situation had to do with whether to challenge the physician’s medical decision making, a challenge that could have been seen as stepping outside her nursing scope of practice or deferring to the physician, even though he was ignoring the patient’s symptoms and remaining safe. That nurse’s comment that “I went beyond my boundaries” pointed to that risk. Should the physician have complained, the nurse’s employer would possibly have criticized her or levelled sanctions against her. Reflecting on what helped her to act in this situation, Participant 3 pointed out that her strong concern for the patient motivated her to take the risk: “But I’d do the same thing again . . . . What’s there to lose? You know, a couple of tests.” By seeing this situation within a broader perspective, the nurse was able to take the risk for the patient’s sake and confront the physician about his medical diagnostic practice.

From a relational perspective, Participant 3 engaged with the patient and attempted to involve the physician in a mutually respectful relationship with the patient and nurse. The nurse’s involvement in this case provides an example of embodiment, in that the nurse’s concern for this particular patient caused her to show concern both during and after her work hours, and, in fact, disturbed her sleep. The physician on the other hand failed to respect either the patient’s complaints or the knowledge and concern shown by Participant 3 until she wrote the concern in the chart. By doing so, Participant 3 effectively improved the power balance between nurse and physician. Although the physician did not enter the relational space willingly, he did come to respect the nurse’s documentation on the chart and then to act on it. Other researchers also have documented some nurses’ willingness to confront physicians, notwithstanding the risks involved (Ahern & McDonald, 2002; Sleutel, 2000; Woods, 1999).
The subjection of dying patients to invasive, uncomfortable, but ultimately futile medical care was particularly problematic for some of the participants. Participant 1 described a patient with multiple health problems. The physician insisted that futile medical intervention be continued, subjecting the patient, in the nurse’s view, to unnecessary discomfort. The patient had told Participant 1 that she wished not to have “heroics,” and the nurse believed that the medical approach to the patient was problematic. Participant 1 stated, “They were doing troponins, CKMBs, all of the cardiac enzyme work up, ECGs with chest pain, every time she had chest pain . . . tons of blood work.” To this nurse, patient comfort was the priority, and the patient’s wishes were clear. Therefore, the nurse decided to discontinue the 2-hourly blood tests:

Ethically, I just couldn’t keep on trying for them to find a spot of blood . . . . Medically, professionally, I had orders that were written in black and white that I should have followed, but I couldn’t, as a person, follow through with it, so I just charted that.

Participant 1 interacted within relational space created with the patient, family members, coworkers, and the nurse manager in order to clarify the patient’s wishes and best interests. She emphasized that she would only challenge life-prolonging interventions with the patient’s consent, “but if I know that it’s their wishes and the family’s wishes, I respect that and I would follow through as best that I could. I would do anything that I could.” Participant 1 showed deep engagement with the patient, and she worked to create relational space in which the patient’s wishes could be ascertained.

Once the patient’s perspective was established, Participant 1, seeing the specific medical orders within a broader view of what was in the patient’s best interests, sought to work with the physician to bring about the patient’s desired outcome. When this proved to be impossible, this nurse’s concern for the patient’s best interests and respect for the
patient’s wishes caused her to ignore orders for tests or treatment that the nurse believed to be excessive. Within these multiple relationships, Participant 1 clarified that the patient’s wishes were paramount, so she acted to bring about care that fulfilled those wishes. Although this nurse knew that negative sanctions might ensue following her disregard of the physician’s order, she did not hide her action, but rather charted it on the patient’s chart. Ethically justified, the nurse disregarded a nurse’s customary legal obligation.

The nurses in this study sometimes resisted pressure to act in ways that they believed would shorten dying patients’ lives. Participant 2 ignored a physician’s order that she believed to be against the patient’s interests, the order being for frequent high dosages of morphine (20 milligrams/hour) for a patient who had suffered a postoperative stroke and who was unable to communicate her wishes. Participant 2, viewing the physician’s behaviour as an attempt to hasten the patient’s death, refused to comply:

[H]e underlined in the orders, “Keep patient comfortable” (underlined, underlined, underlined). “Morphine’s cheap,” he’d come up to me and say, and I felt that he wanted me to hasten her along. . . . I honestly didn’t think she was having any pain. . . . and I knew by giving it to her, it would just hasten her death.

Participant 2 struggled with the choice of giving large amounts of morphine and hastening death or giving the much smaller amount of morphine that she believed the patient required for pain control and ignoring the physician’s wishes. Uncertain about the patient’s wishes, the nurse was unable to consult with the dying woman, who was now uncommunicative. Although the patient had little time left, Participant 2 believed that she had no right to take away the remaining days:

How do I know that she’s not there going, “I want time with my family. I want to hear them talk to me. I want my last few days. I know I’m dying. I want to feel
their hand on my hand. I want to feel them kiss my face?” I wasn’t going to take
that away from her.

Although it was impossible to engage in discussion with her patient, Participant 2
carefully considered that the patient might wish not to have her death hastened and was
satisfied that she had respected the patient’s right to a natural and dignified death:

And she died peacefully, very peacefully. . . . and to me, that’s an ethical issue
because it was a form of euthanasia, in my eyes . . . . I didn’t give it every hour as
it was ordered. . . . but I don’t know what she wanted . . . . I think I was ethically
right.

Participant 2, feeling pressured to give dosages of morphine that she believed
would shorten the patient’s life, encountered an ethical dilemma because of her difficulty
in ascertaining the patient’s wishes. Resisting pressure from the physician and others, this
nurse decided not to give the morphine every hour. Unable to engage with the patient, she
decided to avoid making an assumption that would hasten the patient’s death. Participant
2 felt confident that she could defend her decision, so she was able to open relational
space in order to share with the physician and others that she believed the patient not to
be in pain and could find no sufficient rationale for giving excessive morphine. Within
that ethical environment, the nurse found respect for herself and her decision.

Participant 2 clarified that this decision was specific to the needs she believed this
patient to have. In another example, the same nurse pointed out that she would be very
willing to provide large, frequent dosages of analgesics for patients whose pain required
it for effective control, as long as she clearly understood the patient’s wishes.

Participant 2 related how she had been questioned by a colleague regarding her
provision of large amounts of analgesia to a particular patient. She commented, “I just
remember it just took so long for her to get her pain under control, and I wasn’t going to
back down from that.” Again, Participant 2 engaged with the patient, and with her knowledge of what the patient would wish, stated, “I said, ‘I’m going to give it. This is what she would want.’ Her big fear was to have lots of pain. She didn’t want to die having lots of pain.” In a somewhat different context but knowing the patient’s wishes, this nurse worked, to the extent possible, to bring about the patient’s wishes and best interests.

Both of these participants challenged a medical plan of care that they believed to harm a particular patient, in the first instance, by causing an unnecessarily painful death, and in the second, by using high dosages of morphine that the nurse believed could hasten the patient’s death. Both participants described circumstances in which their ultimate decisions would be different, focusing not only on the patient’s clinical situation but also on the patient’s preference. These nurses described ethical problems arising from their wishes to identify and enact the patient’s wishes, often against the directives of the medical staff.

By engaging in respectful relationships with patients to discern their wishes, or in the case of patients unable to communicate, by inferring the patients’ best interests or possible wishes, these nurses sought to establish the best outcome for patients. These nurses then sought to extend that relational space to include others such as coworkers or physicians to bring about the best outcomes for their patients. In both cases, the nurses acted without fear of harming their relationships with physicians or risking any other harm to themselves, possibly because of their extensive clinical experience and confidence, their own moral clarity, and their skill in opening relational space in which to engage with physicians in more mutually respectful relationships.
In each of these situations, the nurses considered possible ramifications of approaching physicians about lapses in care that they had witnessed, lapses in medical care that participants had viewed as requiring intervention but also as being outside the nurses’ scope of practice to confront. In other studies, nurses had experienced considerable difficulty and risked sanctions within the workplace as they sought to protect patients from incompetent or otherwise unsafe medical care (Ceci, 2004a; Ahern & McDonald, 2002). The nurses in this study interacted with the physicians in their attempts to bring about the desired physician response. Some nurses remained engaged with the patients and their best interests, offering and experiencing respect. They opened relational space in which the nurses, patients, physicians, and others could come together to focus on the patients’ needs and best interests.

One nurse who was secure in her clinical knowledge wrote a notation on the chart to force the physician’s hand when verbal interaction failed, with the result that the physician confirmed the diagnosis and the patient received necessary treatment. Another nurse used careful communication to ensure that a patient received a tracheostomy. A third, certain that the patient wished to avoid intrusive futile actions, discontinued medical tests and assessments that the physician had ordered. A fourth nurse withstood medical pressure to give a patient hourly morphine doses that the nurse considered excessive, explaining that she did not know the patient’s wishes and did not want to assume that the patient wished her death to be hastened.

Other nurses, often remaining engaged with patients’ concerns, wishes, and needs, found it impossible to engage with physicians in mutually respectful ways; they were unable to open relational space in which to bring forward the patients’ needs and wishes.
One nurse used verbal interventions with the physician and nurse manager regarding unnecessary patient pain, but without bringing about a positive response; she then gave up. Another described lack of time, privacy, and personal communication skills as contributing to an inability to stop a physician from attempting a procedure that proved to be beyond his ability. Both of these nurses experienced a dilemma between acting on behalf of the patient on the one hand and maintaining their own professional safety on the other; therefore, riskiness for both patients and nurses pervaded each of these situations. These nurses struggled to maintain relationships with these physicians, even though the physicians’ behaviours had sometimes jeopardized patients’ situations, underlining the fact that these nurse-physician dyads were socially situated in a context of complex and unequal relationships, with patients’ needs supporting the nurses in acting and perceived interpersonal, organizational and societal expectations serving as barriers to that action. It is within these aspects of the complex social context that the nurses found themselves deciding how to act to resolve ethical problems regarding physicians’ care.

Ethical Problems Involving Patients’ Families

Most of the participants described ethical problems that resulted from challenges related to patients’ family members. Nurses are educated to an ideal of patient-centred and family-centred care, in which both the complexity and the importance of family relationships are recognized and considered when plans of nursing care are developed. The various nurses’ licensing bodies describe the clients of nursing as “individuals, families, groups, and communities” (CNO, 2009, p. 4). The participants had developed relationships with patients’ families during their care of the patients, and these relationships varied from being very brief to longer term; many were very significant.
These nurses spoke of a variety of needs expressed by family members that if left unmet, created risks for patients as well as the family members themselves.

Although the nursing ethics literature has provided little documentation of nurses’ concerns for family members as sources of ethical problems for nurses, most of the participants described themselves as caring for patients within contexts in which they also felt concerned about family members’ needs. Family needs included the need for information and the associated need to resolve uncertainty around choices; the need to deal with conflict among family members regarding the best choices for the patients; and the need for additional time for family members to absorb what had happened to their family members.

Participant 1 provided an example of her work to provide timely information to family members in an ambiguous end-of-life situation involving family members trying to decide when to travel over distance to be with a very ill family member:

I have done that with family, though, if the person is not expected to get better and are just deteriorating quickly . . . . they’re starting to have periods where they’re not breathing, and the end might be relatively soon.

Participant 1, while recognizing the difficulty in ascertaining the imminence of death, recognized family members’ needs to be with their loved one and the realities involved. She would advise families:

You know, “When should I call them?” and I always say, “When you think it’s a good time to call, I would do so. I would rather call sooner than later. I would rather they came sooner when things are okay than later when they’re not going to be able to communicate.”

Participant 1 gave family members guidance that was intended to provide information and to help family members make intended contact with the ill family
member before the patient died, avoiding the risk of remorse on the family members’ part after the fact, while recognizing the ambiguity surrounding such temporal decisions.

The nurses also addressed family members’ uncertainty around choices, providing information as well as time, privacy, and support as much as possible. In the scenario discussed next, health care providers had presented family members with the option of a “no code” order. Participant 1 pointed out she often needed to repeatedly discuss with family members how such an order would be carried out. In these situations, Participant 1 sought to provide information to reduce the risk of the family members experiencing fear and anguish through unnecessary misunderstanding:

[M]any times, family doesn’t hear after just one explanation as to what “do not resuscitate” means. They just get very fearful, and they think that means that they [the patient] get parked in a corner somewhere and that’s it, and they’re ignored.

Participant 1 recognized the family members’ need for information in order to understand what a particular advanced directive might mean in terms of their family member’s care. Engaging with these family members and respecting their need for detail as well as their difficulty taking in the information provided, Participant 1 pointed out:

And you have to just keep re-emphasizing that: If blood work becomes invasive, stop. If your IV goes, we wouldn’t restart it, but we would do the pain meds and keep them comfortable . . . . and the doctor would visit . . . . They’re not alone.

The nurses also recognized the need of family members for time and opportunity to absorb the reality of the patient’s situation, including the need to grasp the gravity of the patient’s prognosis. Participant 1 described family members’ responses to such circumstances and the need not only for information and to absorb its impact but also for support in a new and frightening situation:
I’ve had family be absolutelyterrified . . . they’re really, really afraid. They just
want you to be there. They don’t want you to say anything. . . . just . . . let them
know that you’re there.

Developing relationships with such families that involved assessing need as well
as finding the relational space to fulfill such needs was seen by this nurse as an essential
aspect of caring by seeking to reduce the family members’ discomfort and anxiety. Other
nurses also recognized the uncertainty experienced by family members as they attempted
to make the best decision on behalf of the patient. Participant 10 stated:

[F]amilies have a big struggle; they have an immense struggle, trying to decide
what is right, because they want to do the right thing. They want to do what’s best
for their family member if the family member is unable to make that choice.

Participant 10 was similarly sensitive to family members’ needs and fears, and
found ways to be present, engaged, and supportive to family members as well as patients.
Participant 3 echoed this concern and spoke of the broader ramifications of specific
decisions, noting that “and some families – they don’t really realize that certain things
lead to other things. They think if you control one thing, then they won’t get to the other
thing. So it’s difficult.” Participant 3 worried that families that had difficulty grasping the
actual scope and limitations of specific decisions, but not wishing to remove hope,
struggled with the best way to support family members.

Other instances of families’ need for accurate information involved physicians’
requests of family members’ permission to withdraw treatment. According to Participant
8, in some cases, this left family members with the erroneous impression that they had
decided to end a life. Participant 8 commented, “[O]ften the approach that’s taken by
medical staff is to ask the family’s permission to withdraw care, which I personally find
appalling . . . if it’s futile. My belief is, we put families in a really unfair situation.”
Participant 8 approached the physician, seeking to have the family provided with accurate information to ensure that this did not occur if the discontinued treatment was futile.

Participant 8 was sensitive to the burden of guilt family members could experience, noting, “They feel like they are the ones ending their loved one’s [life] and, actually, it isn’t.” The wish to protect family members from unnecessary and unfair experiences of guilt at the end of a loved one’s life caused this nurse to spend time discussing this issue with the physician, who subsequently changed the communication to family members. In this instance, the family members’ need for information and support became the focus of the nurse, who was worried about the possible guilt and remorse that family members might unnecessarily experience.

These nurses believed that family members making decisions on behalf of loved ones required information, supportive presence and guidance. By developing relationships with these family members, often very significant if brief in duration, these nurses were able to recognize the burden that family members bore in situations fraught with stress and uncertainty; identify possible feelings of guilt or remorse resulting from decisions; and work to mitigate those negative outcomes through presence, information, and support.

Information, especially disturbing information about the medical approach to the patient’s care, also could pose a risk for family members. Nurses’ wishes to protect family members could conflict with the wishes to provide accurate information to family members; the nurses’ caring values could conflict with values around honesty and veracity. Two nurses discussed the conflict between the wish to protect the family member from upsetting information and the wish to be honest with them.
In the first instance, a physician’s error had harmed the patient. The physician had failed to intubate the patient in a timely manner, leaving the patient without oxygen for several minutes. Subsequent to that event, Participant 7 experienced a conflict between the wish to have an honest and trusting relationship with the patient’s family member and at the same time recognizing the great risk involved in deciding to reveal the physician’s error: “Well, the ethical part for me is, his wife . . . . still does not understand completely the ramifications of what happened or that we, in my opinion, failed her.”

Participant 7, recognizing the family member’s need to understand the sudden deterioration in her husband’s condition, wished to provide information and support. At the same time, this nurse believed that giving the family member this information would jeopardize the physician and the organization: “I would say, I guess the way I see it is – how I see it as an ethical problem is, I can’t say to the wife, ‘You know. This is the situation.’” By not being honest with the patient’s wife about the medical error, Participant 7 experienced ethical and relational failure in meeting the family member’s need for accurate information.

Participant 9 discussed a patient with cystic fibrosis who had progressed to the point where she was ventilator dependent; rather than exist on a ventilator, the patient had decided to discontinue artificial ventilation and die. During that process, the patient received narcotic analgesics to reduce the discomfort of the respiratory distress she experienced in her last hours. None of the health care providers had discussed the role of analgesics with the patient’s family prior to discontinuation of ventilation. The patient’s mother suddenly became aware that the same analgesics that were providing her daughter comfort at time of death could in fact be shortening her life. Participant 9 said, “What do
you say to families? ‘We do this, but it’s probably going to kill her?’ But I’m sure somewhere in some conversations with certain families that you can have that discussion, but it didn’t really happen here.” Participant 9 saw how distraught the mother was at the thought that the narcotics could be killing her daughter and chose not to provide accurate information, not acknowledging the truth in the mother’s words: “I thought, ‘Oh, my gosh. She loves her daughter like crazy.’ ” At the same time, Participant 9 realized that the patient’s need was paramount: “You’ve got to look at what’s to the benefit to the patient, and we needed to make her comfortable.” Several years later, this nurse still felt ethically uncomfortable about the decision that the health care providers had taken because it had violated an ethical value of honesty. Having been less than honest with the patient’s mother, Participant 9 had provided reassurance that the narcotics were not “killing” her daughter, but years later, she still felt uncomfortable about her less-than-honest approach.

Both of these nurses had ethical problems with their difficulty being honest with family members in situations when the family members had a right to accurate information but care providers’ behaviours were being hidden from them for one reason or another. Within their relationships with patients’ families, these nurses felt they had violated family members’ trust and the trusting relationships that the nurses had wished to foster.

People’s need for information about their family members’ hospital care, prognoses, and choices comprised an area of concern for the nurses in this study. As already discussed, at times, the nurses experienced ethical problems as they determined what or how much information to provide; the ambiguity of patients’ situations sometimes created difficulties for the nurses in providing accurate information. The
nurses’ attempts to provide information to family members occurred within a context of complex relationships, some of very brief duration, and in a hospital culture in which families often asked the nurses questions that according to societal norms, would normally have been answered by the physician. However, physicians are rarely at the bedside, but nurses are easily accessible to families. Within this context of uncertainty, these nurses worked to assist families, provide information, and support family decision making.

Although family members’ need for information and support was the focus of the nurses in this study, several of the participants described difficulties that occurred when disagreements occurred among family members. The nurses were particularly concerned when family members who tried to make decisions for patients who were unable to make their own decisions or express their wishes could not agree among themselves. Disputes among family members about decisions on behalf of patients constituted a difficult type of ethical problem in which the nurse saw the patients’ care decisions altered or delayed, or the patients’ best outcomes abandoned. According to Participant 4, delays in patients’ treatment caused patients’ care to suffer:

When a family member disagrees, then we have a big problem . . . . if one family member thinks that the mother should have this treatment, and another family member thinks that they shouldn’t have this treatment, everything’s on a halt.

From the perspective of Participant 4, the failure of families to come to a consensus led to delayed decisions that harmed the patients. The fact that others’ interpersonal conflicts delayed patient care was an ethical problem for the nurse, violating the priority of relating to one another in a way that would bring about the best outcomes for patients. Engaging with families in respectful relationships to resolve such
issues was a problem for this nurse, who believed that family members sought the advice of physicians, not the nurses; if the physicians were not available or did not engage with the family members, the problem remained unresolved.

Participant 10 noted that family members varied considerably in the discussions they carried out with one another prior to patients’ hospitalization, leading to conflict among family members:

And the family is coming and saying, “Well, I know this is what Mom would want.” Then you have the next one coming and saying, “Oh, she wouldn’t want that, we’ve discussed this” . . . . that’s when those big things come up.

Participant 10 clarified that families dealing with uncertainty could have great difficulty in ascertaining the patients’ wishes, especially when various family members had different experiences of family members who were now patients and unable to express thoughts or wishes: “It’s not so much that you have something wrong that’s being done. It’s that you have family not understanding what their parent or whomever would want.” She believed that families could reduce such conflicts among family members and uncertainty around loved ones’ wishes by carrying out conversations beforehand, thereby facilitating a better outcome for patients and the other family members.

Conflict also could exist between a family member possessing power of attorney and other family members. For example, Participant 5 recounted an example in which a patient’s second wife directed that his care, although futile, be continued for 9 long months: “And the son and daughter would come in and they were just devastated when they saw their father like that, because he was just . . . he looked like something from a prison camp, by the end.” Recognizing the distress of the patient’s children but unable to effect a better outcome for their father, this nurse’s ethical problem remained unresolved.
Participant 5 felt the family members’ anguish, engaged in a relationship with them, but was unable to resolve the situation because of the legally threatening approach used by the patient’s wife in asserting her power of attorney.

At times, family members attempted to prevent other family members from visiting a patient. Participant 9 described an example in which a patient’s daughter attempted to withhold from her father the fact that his wife was in hospital:

I saw it as an ethical issue because I thought that the husband had a right to be involved and know how sick his wife was, and I just felt it was morally wrong to exclude him without knowing all the facts, and that he should be aware that his wife was so ill.

Having developed a relationship of trust with the daughter, this nurse was able to resolve the issue, and the daughter contacted her father. Subsequently, the patient received increased support resulting from her husband’s presence, and the family conflict was resolved.

Nurses in the examples just described expressed concern when patients’ family members expressed conflicting opinions about the best course of action for patients. The concerns included delays in patients’ receipt of care, exclusion of possible supports for patients, anguish of family members unable to alter plans of care they believed not to be in the best interests of patients, and families’ difficulty making decisions. These nurses, working to develop relationships with these families, attempted to overcome these conflicts by providing information, support, and advice. At times, the nurses were able to act within these social contexts to bring about positive outcome for their patients. However, not all of these nurses were able to resolve these issues, and moral distress was the result for some nurses when family members’ actions conflicted with patients’ best interests, in the nurses’ views.
End-of-life situations often bring associated ethical issues for nurses, and this is especially true when family members are absorbing the reality of tragic situations and need time to come to terms with them; in these situations, nurses, who are focusing on the needs of patients as their main concern, also may recognize the needs of family members. Two nurses in this study described situations in which family members seemed to need more time with their loved ones at the end of life.

In the first instance, Participant 2, not knowing whether the patient would have consented to shortening her life with analgesics, reflected on the family member’s seeming need to spend more time with her mother:

I do remember putting myself in the family’s position, and if that was me sitting there . . . . she had a handicapped child that she’s always taken care of, and now the handicapped daughter was sitting there taking care of her mama.

Unable to ascertain the wishes of the patient, Participant 2 inferred that the family needed to spend time together. She used that information in her decision not to participate in shortening the patient’s life with dosages of morphine that she believed to be unnecessarily high; another effect of that decision was that the patient’s family member would have more time with her mother as the mother died.

In some end-of-life circumstances, family members had difficulty coming to terms with the sudden and dramatic changes in their loved ones’ conditions. The family of a young man experienced this difficulty: His neurological condition had suddenly altered, rendering him dead by neurological criteria. The mother’s difficulty coming to terms with health care providers’ request to discontinue treatment to her son resulted in the family refusing and the nurse uncomfortably “nursing a dead body” but also understanding the family’s need for time to come to terms with the futility of continuing
his treatment. Realizing both the inevitability of the patient’s death and the difficulty of the family, Participant 8 reflected about the family’s refusal to withdraw treatment: “For his family . . . I think it’s quite possible, actually, that all of the time that we had to ventilate him and give him drugs actually gave his family time to catch up with staff.” Although it was morally difficult for Participant 8 to participate in keeping the patient alive instead of allowing the patient a dignified and peaceful death, it was with an understanding of how difficult the situation was for the family as they tried to grasp that their young family member had suddenly died. Both of these nurses expressed sensitivity to the family members’ need for time with their loved ones at the end of life, in the second example time to grasp a sudden and devastating change in a loved one’s condition.

In each of the vignettes describing the concerns or unmet needs of patients’ families, the participants expressed an interest in the family members’ well-being and a willingness to recognize the importance of relationships with family members to patients. By developing meaningful relationships with family members, often on a very brief timeline, these nurses were able to work within a social context of multiple complex relationships to provide patients with care and families with information, support, and a sense of security that the nurse was present. The nurses used relational space among the patients, family members, and nurses themselves to attempt to bring about the best outcomes for the patients primarily but also for family members. At times, the nurses had great difficulty within this context with the actions of family members on behalf of patients, especially family actions that seemed to advance the interests of the family
members rather than those of the patients. The following discussion explores those difficult situations.

Family Decision Making on Behalf of Patients

Although the nurses in this study believed that the patients’ families had an important role in the patients’ care, they sometimes found themselves torn between care for the patients and care for the family members. Uniformly, the nurses determined that the patients’ interests were foremost. As Participant 10 summarized, “We tend to side on the patients’ side.” Situated within a dynamic of relationships, Participant 10 attempted to engage with family members in order to bring about a better understanding of and respect for the patient’s situation, needs, and rights:

And sometimes then you have to take the family aside and say, “Well, now, you put yourself in their place overnight, please, and you think about this. How much are you willing to do if you were in their bed?” But you do that gently, of course. You just don’t come out like a tyrant or something.

Recognizing that family members might at times not recognize that their wishes for the patients might be different from the patients’ own wishes, this nurse described ways of opening relational space with the family members to engage in consideration of this patient’s needs, for example, by encouraging the family members to empathize with the patient.

Situations in which patients’ clinical prognoses were extremely poor, but family members insisted upon all life-continuing treatment, constituted an ethical problem for the nurses. These nurses believed that family members violated patients’ best interests when they focused on their own needs rather than those of family members who were patients.
For example, a patient who was dead by neurological criteria continued to receive care at the demand of his family. Although understanding how difficult the situation was for the family, Participant 5 nonetheless focused on the needs of the patient rather than those of the family members, noting that “and ethically, for the nurses, it was difficult because . . . we were basically nursing a dead patient.” Focusing on the patient’s right to a dignified death, Participant 5 struggled with the family’s decision that violated that right. A sister of the patient’s mother, a nurse, ultimately arrived and confirmed the situation for the patient’s mother. As Participant 5 recounted, “I explained the situation, and . . . the sister . . . did the cornea, the pupils, gag, and she said, ‘He’s brain dead.’ ‘Oh, okay.’ We withdrew him from the ventilator and that was it.” Once the other family member arrived and confirmed for the family the reality of the patient’s neurological death, his family then allowed care to be discontinued. Reflecting on this difficult situation, Participant 5 pointed out how the ethical problem was resolved: “[I]n that situation, it was more trying to facilitate whatever it was going to take to get mom to understand that her son was not going to make it.”

These examples showed the nurses’ focus on the interests of the patients, as well as the ethical problems that the nurses could experience when family members’ decisions violated patients’ interests. They also showed how nursing staff could engage with family members and use this relationship to find ways of resolving ethical problems, namely, the difficulty of family members trusting grave information when received from strangers, and the hospital staff members’ difficulty in seeing persons kept alive in an undignified manner when further care was futile.
Although one of the aforementioned examples involved a sudden turn in the patient’s situation, allowing the nurse to understand the family’s hesitation in agreeing to discontinue treatment, other examples involved more complex and difficult motivations on the part of family members. One patient’s son refused to discontinue the artificial ventilation required to keep his father alive. The father, wishing to die, continually attempted to remove his endotracheal tube. His son directed nursing staff to use wrist restraints to prevent such removal. The son’s legally threatening way of expressing his wishes seemed to preclude discussion about his father’s best interests, according to Participant 4: “[T]he family member said to the staff, ‘Do not untie him, because if he pulls that tube, you’re in trouble.’ ” The ethical problem for Participant 4 occurred because, as she pointed out, “You knew what he wanted, and you knew that he knew what he wanted. So it was difficult to help him along, because there was another block there. There was this family member that was balking.” Trying unsuccessfully to speak to this family member, Participant 4 sought others to speak to on behalf of the patient: “That’s why I had to go to higher committees and for them to speak, because really, the family member doesn’t listen to a nurse.” Compounding this situation, the hospital’s ethics committee was in its infancy and was not functioning completely. Participant 4 recounted:

[T]he ethics committee . . . wasn’t in full tilt . . . Some of these issues have to be taken to a bigger group of people where they can decide, where other people are involved, like the chaplain, ethics committee physician . . . and lawyers.

Participant 4 found herself forced by a legally threatening family member to restrain her patient physically to prevent his self-extubation and death; she believed that she was prolonging the patient’s uncomfortable and poor quality life against his will
simply to prevent the son from take legal action against her, the medical staff, and the hospital. The nurse in this situation had little opportunity to influence the problem solving around how to deal with the son’s ignoring his father’s needs because the decision to prolong the patient’s life was made by the medical staff and the patient’s son. In this relational context, the nurse was unable to find any interpersonal way to influence the outcome; again, moral distress was the result for the nurse. Participant 4 wondered whether a wish to avoid a lawsuit motivated the medical staff and hospital to agree with the son’s decision: “It becomes very difficult, and hospitals want to avoid lawsuits.”

As described, at times, the nurses found themselves caught in conflicted relationships with patients’ family members, sometimes in an interpersonal context in which the doctors seemed to support the family members. One such situation involved a gravely ill individual whose wife refused to agree to withdraw treatment, even though her husband’s situation was medically futile. The circumstances involved a variety of legally threatening actions by the patient’s wife, including letters of threat or complaint to the hospital administration and ministry of health; other legally threatening actions, and various behaviours, such as secretly videotaping her husband’s caregivers. Participant 5, recounting this wife’s disruptive behaviour on the unit for more than 9 months, indicated that the goal of the physicians again seemed to be avoidance of litigation by the wife, with the result that the patient’s death was protracted and extremely difficult:

They were really feeding into the wife. It was almost like they weren’t even considering the patient. They were more concerned . . . the organization was more concerned about her suing them! Why else would they get the lawyers, the hospital lawyers, involved?

Participant 5 deplored the way in which medical staff abandoned the patient’s best interests: “For me, my ethical dilemma was that we were doing this to this man, and that
we were torturing this man, and that we were putting him through everything that we were.” Although it was difficult to provide nursing care to a patient who died slowly over a 9-month period, Participant 5 empathized with the family member: “And, you know, I understand families wanting to keep their loved ones alive forever and ever, and they don’t want to lose their significant other.” However, she also recognized the importance and, indeed, the priority of considering the patient first: “But I think there needs to be a point where you say, ‘Stop, enough. We’ve done everything that we can,’ and I think with this gentleman that was never said, and that was never brought up.”

Similar to the instance of the patient forced to endure ventilation when he clearly wished to die, this example illustrated the difficulty experienced by nurses when patients’ family members focus on their own needs rather than those of the patients. Legally intimidating behaviour on the part of family members again resulted in the medical staff agreeing to continue treatment accompanied, in this case, by legal staff directing interpersonal approaches the staff would take with the patient’s wife; these powerful others’ decisions left Participant 5 feeling marginalized and silenced. Again, unable to alter the patient’s situation, the nurse agonized over her participation in this futile treatment, attempting to resolve ethical concerns within a social context of layered relationships among patients, nurses, physicians, family members, and others, in this case, a relational context in which barriers existed in the relationship between the nurse and the family member.

Occasionally, the decision of the family member is to end a family member’s life instead of prolonging it. A physician allowed one patient to die upon the advice of the patient’s sister. According to Participant 7, the patient,
Who had broken his pelvis and suffered some internal injuries, but whose health situation would not normally have resulted in discontinuation of treatment and death, was allowed to die. He wasn’t even old, but he had had this discussion with his sister many times that he never wanted to be handicapped in any way, that people like that were gimps.

The patient, who was extremely overweight, required hip fixation and long, arduous rehabilitation. Participant 7 stated, “He was . . . 300 pounds or something, so yes, his rehab from the hip surgery would have been long and drawn out and a tough one.” Unable to ascertain the wishes of the patient, the physician sought the advice of his sister, who indicated that the patient would not want to live with such a disability. The physician subsequently took the decision to withdraw treatment from the patient, who only needed hip surgery. This situation was complicated by the fact that the patient was a drug dealer and alcoholic, and Participant 7 was left wondering whether the patient’s lifestyle had influenced decisions around withdrawal of treatment: “You know, it’s like, ‘Ooooh . . . have we decided because this person is not a particularly good citizen in our minds? Like, have we made a judgement here? And almost, are we executing someone?’” Participant 7 expressed discomfort with the decision to withdraw treatment from a patient whose condition would normally not have been life threatening simply on the basis of information his sister recounted to the physician. The ambiguity around the patient’s wishes was never resolved.

In such a circumstance, a nurse trying to advocate for the patient would have had no direct knowledge of the patient’s wishes but would have had to rely on clinical knowledge and experience, which in this case, would have informed the nurse that the decision advocated by the patient’s sister was extremely unusual and possibly unnecessary. In this instance, the physician explained his and the family member’s
decision to nursing staff and sought the input of the nurses. This represented a rather unusual approach in which the physician engaged with others, including nurses, and opened relational space in which to discuss and consider the ethical problem. Several patients in these examples experienced difficult or prolonged deaths, with one seeming to experience a premature death, all at the behest of their family members. In each situation, the nurses underlined the differences between the actual deaths that the patients experienced because of family decisions and the more peaceful and dignified deaths that would have reflected the patients’ best interests.

The International Council for Nurses (ICN, 2006) Code of Ethics reflects the centrality of this dilemma for nurses. That document articulates the goals and roles of nurses as focusing on the promotion of health, prevention of illness, restoration of health, and alleviation of suffering for the person requiring nursing care; therefore, although nurses may wish to work with and support families, patients’ health and interests are properly the nurses’ first concern. Foundational values include the dignity of patients, alleviation of patients’ suffering, and promotion of peaceful death (ICN, 2006). The nurses in this study cared for patients whose family members made decisions that violated such nursing values. They experienced ethical problems as they attempted to reconcile the decisions made by the family members that resulted in difficult, protracted, or otherwise problematic deaths of the patients with the dying process that the nurses believed the patients should have had: dignified, swift, and comfortable.

Within the complex relationships involved in these situations, the nurses found family members sometimes unavailable for the development of a relationship with the nurses, and powerful social and legal forces ranged in support of family members
possessing power of attorney, against the nurses’ perspectives. These situations inevitably also involved differences between nurses and physicians, with the physicians being the ones who wrote the orders to continue patients’ treatment. Therefore, the nurses’ ethical problem solving was socially situated in a context of multiple relationships in which legal powers, both of family members and physicians, directed the outcomes.

Although few researchers have described details of the role of family members in nurses’ ethical problems, some have documented nurses’ moral distress in situations when the patients’ best interests or wishes are ignored by family members who are directing patients’ care (Enes & de Vries, 2004; Lorenson et al., 2003). The nurses, forced to provide life-prolonging care against patients’ interests, experienced moral distress and sometimes had difficulty maintaining good relationships with family members whose decisions were seen as violating patients’ best interests.

In this study, the nurses developed relationships not only with patients but also with their families, to whom they provided support, information, and a caring presence. The nurses encountered some difficulty when they believed that the needs of patients and the needs of the family members conflicted, but they focused first on the patients and the patients’ interests. The nurses worked to provide information, reduce uncertainty, and deal with conflicts between family members, all of which constituted important relational approaches for the nurses. However, family members’ choices could and did create ethical problems for the nurses. Family members’ decisions around end-of-life situations constituted particularly problematic situations for nurses, such as when the nurses believed that the family members placed their own needs ahead of the patients’ needs. The nurses’ ethical deliberations often were socially situated within a complex of
relationships involving one or more family members; physicians; and, at times, the medical hierarchy supported by legal advisors. In those circumstances, the nurses felt marginalized and experienced moral distress as they saw that the patients’ interests were being ignored.

**Ethical Problems Related to Coworkers’ Unethical Behaviour**

Nurses work closely together in the hospital environment, and they expect to provide assistance to one another when the need arises. However, over the past 2 decades, there has been increasing recognition of the bullying that senior colleagues inflict at times on new nursing graduates (B. Kelly, 1996; McKenna, Smith, Poole, & Coverdale, 2003). Since the late 1990s, numerous researchers have documented interpersonal tension and conflict as pervasive elements in nurses’ coworker relationships in multiple locations, including Australia (Lewis, 2006); the United States (Cox, 2001); and the United Kingdom (Randle, 2003).

The nurses described support from nursing colleagues as a very important aspect of their ethical problem solving. However, those nurses also discussed interpersonal issues among coworkers, including verbal abuse, failure to assist, and failure to acknowledge errors. “You see nurses that are maybe not as nice to their patients . . . . but you don’t say anything . . . . I would never challenge her on that because she would chew me up and spit me out” [Participant 5]; “Yes, because it’s one of the hard line nurses . . . . if I would have said something, I would have been so uncomfortable having to work side by side with that nurse, you know?” [Participant 6]; “Probably if I said something to them, they’d probably stop talking to me . . . . I’ve got to work with that person all the time, and, boy, that’s going to be uncomfortable” [Participant 2]. Given the literature on
interpersonal conflict and tension as important aspects of the nurses’ work experience, it is important to take into account evidence of such problems.

For the nurses, the provision of assistance to colleagues was considered an important aspect of cooperative professional behaviour, but the nurses sometimes violated this value, as in the following example. Participant 1 was alone with a violent patient who had gotten out of bed, entered the bathroom, and threatened her physically when she tried to help him back to bed. The nurse sounded the alarm, but no coworker came to her aid. This very experienced nurse described herself as being very distressed that her colleagues, knowing the potential danger to her, failed to provide assistance and showed a lack of concern for her safety:

It was quarter to 12. Night staff were on, and they were still fighting over who was going to come look after this guy; they weren’t coming. So I pulled the . . . the bathroom emergency bell. Nobody came. The guy picked up the IV pole and . . . he was going to hit me over the head with it, and I was going, “Come on, we’re going back to bed” . . . and I got him into bed. I got him there, and about midnight, they came in and all the bells were still going and going and going, and I was so upset that no one cared about my safety, knowing this guy had been really wild, quiet one minute, wild the next; knowing, because they had been on and dealt with him. . . . and then when they did come, their attitude was like, “Why are you calling? What are you calling me for?” . . . I was so upset, and I’ve never had that lack of concern for people that I work with; and it began to dawn on me that maybe that whole ward staff needs somehow to be meshed better, it needs to support each other. It sure wasn’t there, it was like, “Every man for himself, and I’m out of here.”

The other nurses’ failure to provide assistance violated a norm of good coworker relationships (Farrell, 1997) and undermined the trust that this nurse felt in her coworkers’ willingness to help her, even in situations that they should have understood as potentially dangerous for her. This example underlined the interpersonal reliance of nurses on one another and the serious results of withdrawal of that mutual support.
Given the interdependence of nurses on one another, it is not surprising that the nurses described problematic coworker behaviours that they had decided not to confront, anticipating that such confrontation would result in increased conflict and harm to the coworker relationship. Although the nurses in this study did not characterize the work setting in terms of interpersonal conflict and tension, there was evidence of actual or potential coworker conflict and tension, as well as positive support and collegiality, in the participants’ descriptions.

The interdependence of nurses may have contributed to the nurses’ decisions not to act on ethical problems related to coworkers’ behaviours, fearing that such action could have damaged coworker relationships and could have resulted in a loss of their ability to rely on other nurses for assistance and advice. Five participants described ethical problems arising from their coworkers’ behaviours, including coworkers’ unprofessional behaviours arising from substance abuse problems and a range of care lapses such as documenting care that was not completed, failing to provide adequate levels of care, and verbal abuse of patients. The nurses’ ethical problem solving in these situations occurred in a seemingly fragile interpersonal social context.

*Ethical Problems Associated With Coworkers’ Substance Abuse*

Nurses’ access to medications, especially to narcotic analgesics, brings with it the risk that occasionally nurses with substance abuse problems will take medications meant for patients; both theft and caring for patients while under the influence could be aspects of this ethical problem. In addition, nurses might consume alcohol prior to attending for work, leaving the impression of possible inebriation, with similar associated ethical problems for other nurses. This study included examples of nurses’ ethical problems
regarding how to proceed when they suspected such occurrences. Not wishing to harm coworkers or allow patients to be harmed, these nurses worried on the one hand that coworkers might be wrongly accused and, on the other, that patients might be jeopardized by the actions of nurses under the influence of a mind-altering substance.

One example of this dilemma involved a nurse’s shock upon discovering that a coworker had been collecting and using waste narcotics left by others in the medication room for other nurses to sign and waste, instead of disposing of the waste narcotics; the nurse subsequently lost her license. Discussing subsequent similar situations, Participant 1 described her struggle to avoid falsely accusing another while at the same time preventing opportunities for such behaviour by another coworker: “I hate to point fingers without strong evidence . . . . Do you come forward when you suspect? Do you confront that person yourself?” The resolution of the problem used by Participant 1 was to take responsibility for leftover narcotics: “just never leave any wasted meds around ever, when she was on, and the word just kind of got around.” The nurses in this situation decided to follow the hospital policy regarding wasted narcotics, thereby preventing any nurse from collecting and using them; they avoided falsely suspecting and then confronting a coworker; and they protected nursing staff members from impairment related to by taking such wasted narcotics. In this way, the nurses avoided jeopardising coworker relationships. However, the veil of suspicion continued to hang around that colleague, without clarity regarding the accusation. If that nurse did have a substance abuse problem, this approach would not have resolved that issue.

Another nurse took up the theme of nurses confronting coworkers suspected of arriving at work under the influence of drugs or alcohol, recalling that when a non-RN
coworker had once arrived at work smelling of alcohol, the nurses became concerned for patients’ safety and confidence in the staff. Participant 2 and her coworkers decided to contact the supervisor. The supervisor arrived; confronted the coworker, who was not an RN; and decided to send the coworker home. Participant 2 recounted the very negative result of her actions: “Well, we had . . . huge fallout from that . . . . She said, ‘How dare you do that to me? Why didn’t you come to me beforehand, before you called the manager? You’re a bunch of’ . . . .’”

That experience changed the way Participant 2 dealt with such issues: “In retrospect now, if something bothers me, I’ve learned from that. I just go right to the person . . . I won’t go above the person anymore.” Participant 2 recounted that her relationship with that coworker was destroyed by her action, and she expressed remorse at not having approached the coworker as a first action, rather than reporting her to the supervisor. However, Participant 2 believed that she had an obligation to report the behaviour: “When you work for the hospital and your union will support you, you have a duty to report that, and that’s why we had to do what’s right, and we did, but I’ve regretted it, absolutely.”

In the example, the cost of professional accountability was the loss of a coworker relationship, which would create awkwardness each time these coworkers worked together. However, confrontation was not necessary in each instance, as illustrated when a participant suspected that a coworker was substituting a patient’s Tylenol 3 with Tylenol Extra Strength and then taking the Tylenol 3 herself. Participant 2 said that once she had reported her suspicion to the nurse manager, she was not required to take any further action because the nurse manager and others brought about the nurse’s eventual
detection, suspension, and transfer to an area where she had no access to narcotics.

Reflecting on the situation, Participant 2 underlined the importance of reporting the nurse’s theft and substitution of a patient’s narcotic drug:

I think I reported it because it was wrong, it was wrong, and now that we’re talking about it, I never even thought of any repercussions to myself because it was wrong. She was stealing narcotics, and that patient was not getting his pain relief.

Participant 2, adamant that it was necessary to report any theft of narcotics, acted without considering the interpersonal risk involved.

Each of these examples of coworkers’ use of drugs or alcohol at work involved the nurses’ concern to protect patients, concern about the illegality of a coworker’s behaviours, and/or concern about a potential loss of regard for nurses in general by patients. At the same time, the participants struggled to avoid false accusations and so tried to ensure that they avoided unnecessary harm to their coworkers and their relationships with those coworkers. For these nurses, maintaining trusting relationships with coworkers proved challenging in these situations. Maintaining trustworthiness in their relationships with patients, other coworkers, the organization, and the profession seem to have been higher priorities for these nurses at the time.

Ethical Problems Associated With Coworkers’ Care Lapses

The nurses’ observations of coworkers’ lapses in standards of care also caused ethical problems for the participants. Possible actions to resolve these ethical problems could and did test the nurses’ interpersonal relationships. Many of the nurses described themselves as avoiding interfering with another nurse’s care for a variety of reasons. However, integrity lapses did draw nurses’ attention. An example involved a nurse’s frustration when a coworker charted care that she had not carried out, such as dressing
changes. The participant was unable to persuade the other nurse to chart accurately and honestly. Participant 2 recounted her decision not to escalate her actions, reasoning that the lapse involved a dressing change, not a missed intravenous antibiotic:

I just believe, don’t lie about it, and just chart: “Dressing not changed; ran out of time” . . . it’s not a big deal . . . but, you know, you just can’t falsify your records by saying you’ve done something. It doesn’t happen often, it’s just certain people . . .

Participant 2 stated that the risk to patients informed her approach to the coworker and her perception of the ethical problem: “If the patient had been harmed by it, then it probably would be an ethical issue. By not changing the dressing isn’t an ethical issue; falsifying the record is an ethical issue.” Although the coworker’s lack of honesty troubled this nurse, she declined to report the nurse to the manager, having assessed the possible risk to the patient. She said that she would probably have reported the problematic behaviour to the nurse manager if the coworker had jeopardized the patient’s care in an important way.

This participant’s decision not to act seemed to be the result of a consideration of risks to the patient and to herself associated with reporting specific lapses or declining to report. She recognized the possibility of severely damaging her relationship with the other nurse, the possibility that other colleagues might view her as untrustworthy, and the possibility that the organization might view her as a meddler and troublemaker. The interpersonal stresses and strains in the nursing workplace involved both ethical problems and issues around relationship maintenance. These two issues seemed to conflict at times, resulting in nurses deciding not to pursue issues around other nurses’ behaviours if they believed the behaviours to result in low risk for patients. Consideration of the interpersonal repercussions with coworkers of acting to resolve ethical problems was an
important aspect of the social context in which the nurses’ ethical problem solving occurred.

Part of the nurses’ interdependence involved caring for one another’s patients during work breaks. Extremely awkward situations could occur when a nurse discovered that a coworker had failed to provide adequate care during the nurse’s absence on break. For Participant 6, the coworker’s behaviour caused multiple problems. Arriving back from her break, Participant 6 found that her patient was in respiratory distress, clearly having had no care from the coworker, who had accepted responsibility for the patient during the break. The charge nurse, who had been present during the problematic episode, created a further problem by indicating to the nurse manager that Participant 6 had actually failed to act. Like Participant 2, who had regretted reporting her non-RN coworker to the supervisor, Participant 6 also experienced negative repercussions following her action:

> It sparked a whole set of bad relationships afterwards between myself and that nurse and the charge nurse and everybody. The head nurse acted. She took a written documentation from me . . . and she worked on it, but nothing ever happened to that nurse.

As in the previous example, this nurse also proceeded with caution subsequent to this occasion. The participants’ efforts to resolve ethical concerns related to coworkers’ actions provided instances of the socially situated complex of interpersonal relationships among nursing colleagues within which ethical problems are considered. The interpersonal repercussions of reporting a care lapse diminished the likelihood of nurses’ subsequent actions designed to correct lapses in patients’ care.

The nurses described witnessing and otherwise becoming aware of other nurses’ unprofessional or abusive behaviour toward patients, and then having to decide how to
proceed. In one example, a patient was extubated and recounted to Participant 6 another nurse’s abusive verbal behaviour that he had experienced when intubated and on a ventilator, alert but unable to speak. Participant 6, having conferred with another nurse, advised the patient’s wife to speak to the nurse manager. She decided not to convey the complaint herself but to advise the patient’s wife to report the incident. In this way, she chose a safer compromise in which she was able to participate in problem resolution. The nurse manager dealt with the issue, and Participant 6 avoided possible repercussions by deciding not to act herself, but to encourage the patient’s wife to deal with the situation herself. Resolving the ethical problem and maintaining a trustworthy relationship with the patient and his wife, as well as the relationship with the problematic colleague and others, seemed to be the nurse’s goal.

Participant 5 similarly described a coworker whose verbal interaction with patients failed to meet standards of nursing practice. In the participant’s opinion, “You see nurses that are maybe not as nice to their patients and you think, ‘Gee, you shouldn’t be like that towards that patient,’ but you don’t say anything.” Participant 5 decided not to intervene, perhaps viewing the behaviour as not sufficiently problematic to mention or possibly believing that change in the behaviour would be unlikely.

A final participant described how she resolved the conflict she felt when caring for a drug-addicted patient with a directive to give that patient narcotic analgesics, with the result that she felt somewhat like a drug pusher. She indicated that her resolution focused on the fact that the goals of that particular hospitalization did not include drug rehabilitation; this resulted in her focus on patient comfort rather than on avoidance of substance abuse. She indicated that having ascertained that the patient’s physician was...
well aware of the drug problem, she was able to provide the narcotics as indicated
without a great conflict, although she reflected that the patient’s family might have
difficulty with the care providers’ course of action. Participant 3 contrasted her approach
with that of other nurses who “turn into the role of a mother, and ‘No, you’re not having
any more; that’s it’ . . . [or] play games with the amounts they’re getting.” Participant 3
articulated how she had resolved the seeming conflict between the medical order to
provide narcotics to a drug addict and her recognition that the drug addiction should be
treated. She expressed concern about some nurses’ tendency to withhold narcotics in such
situations, but in the absence of a concerted treatment plan for the drug addict and
without a shared therapeutic rationale.

These participants described a variety of ethical problems related to coworkers’
behaviours. In these socially situated contexts, the ethical problem involved the need to
protect patients from possible harm and a desire to protect coworkers and coworker
relationships. Some participants provided insight into their decisions of whether or not to
act, depending on the probable results for the patient and coworker relationships. The
small amount of research on nursing coworker relationships has focused on the nursing
workplace as characterized by conflict and tension (Cox, 2001; Farrell, 1997, 1999;
Randle, 2003); research on nurses’ ethical problems arising from coworker behaviours
has been almost nonexistent. The nurses in this study experienced these problems in a
context of complex relationships and relational norms that are discussed in later chapters.

Conclusion

The number and range of ethical concerns described by the participants provided
insight into the everyday ethical life of hospital nurses. Within a specific organizational
context, the nurses experienced ethical problems related to decisions made by others that affected patients: decisions of physicians, family members, and nurses’ coworkers. These issues have all been touched on in the research on nurses’ ethical problems, whether associated with physicians, family involvement, or coworker behaviours, all within an organizational context of multiple and layered relationships. The relational sources of ethical problems had to do with violations of the patients’ rights, wishes, best interests, or best outcomes as perceived by the nurses. This chapter presented these sources of ethical problems in the same order as in the conceptual framework. The examples provided evidence and illustrations of the nurses’ ethical problems as well as the social contexts surrounding those problems. The nurses’ actions related to these problems ranged from doing nothing, through engaging with relevant others in discussion of the ethical problem, to confrontation, and finally on occasion to acting in ways that violated written doctors’ orders or the boundaries of the nurse’s normal scope of action.

The nurses experienced some physicians’ communication that was so disrespectful, demeaning, or otherwise problematic that it created an interpersonal context that would reduce the likelihood of the nurse engaging with those physicians to resolve ethical problems. It also would reduce the likelihood of the nurses opening relational space in which to work with the physicians, together with others, to resolve ethical problems. Nonetheless, the nurses provided examples of their initiatives in developing mutually respectful relationships with some physicians, engaging with those professionals in discussion of ethical problems, and ultimately resolving at least some of the problems that physician actions had caused or to which they had contributed. Some nurses showed successful use of respectful suggestions, engaged discussion, assertive
suggestions, and both verbal and written confrontation. Finally, the nurses occasionally described instances in which they ignored verbal or written doctors’ orders. Several participants even identified problematic situations around family involvement in care decisions.

The nurses valued supporting and providing information to patients’ families, although acknowledging that patients were their first concern. Family members’ decisions that met their own needs rather than those of the patients resulted in ethical problems for the nurses that they attempted to resolve. Some of these decisions involved physicians as well as family decision makers, making it less likely that the nurses would be able to influence the situations; prevented from facilitating such resolution, some of the nurses experienced moral distress. The nurses described themselves as taking various actions in relation to the ethical problems related to family decisions. These included acknowledging the family members’ right to make decisions and therefore doing nothing; engaging with family members to provide information, advice, and support regarding patients’ situations; confronting family members to increase their empathy with patients; and using the influence of other family members on occasion.

While respecting the needs and wishes of family members, the nurses saw the patients’ wishes, rights, and needs as paramount. The nurses at times found themselves unable to act on behalf of patients, particularly in instances involving decisions by physicians and family members that were supported by the hospital administration and its legal advisors; in such situations, the nurses believed intervention to be futile, so they abandoned attempts to alter the outcomes. These nurses described their anguish over the
patients’ rights or best interests being abandoned, suggesting that the nurses’
powerlessness resulted in moral distress.

This study revealed coworkers’ behaviours and the impact of those behaviours on
patients to be a source of ethical concern for the nurses. In this study, risks to the patients
of not acting seemed to influence the nurses’ resolution of ethical problems around
coworker behaviour, as did the risks to the nurses and the nurses’ coworker relationships
of acting. This provided evidence of a situational analysis carried out by the nurses. The
relational importance of maintaining good working relationships within the health care
team was a very real priority for these nurses, who acted only when they saw clear risks
to patients, such as from a substance-impaired coworker.

In summary, the ethical problems identified by the nurses represented a range of
topics, including tension around physician communication, care decisions, and
behaviours; family decision making for patients and the appropriateness of end-of-life
care; coworkers’ communication, care decisions, and behaviours, including impaired
behaviour; and, finally, the organizational context within which nurses worked in
relationship with others to resolve ethical problems. The nurses described the ethical
problems in terms of risk or harm to patients, and their actions to resolve these problems
were socially situated and included suggestions; discussion; challenge to orders;
confrontation; choice to ignore doctors’ orders; decision to report others to the
administration; and at times, the decision to do nothing. From a relational ethics
perspective, the ability of these nurses to resolve ethical problems rested on their ability
to engage with others with mutual respect and open relational space in order to reflect on,
discuss, and work to resolve ethical problems. In such an ethical environment, nurses and
others could bring forward patients’ needs and concerns in a context of multiple complex relationships, and bring about better outcomes for patients. This chapter provided a discussion of nurses’ ethical problems in relation to their relationships with patients, physicians, families, and coworkers. The resolution of these problems and the resulting actions occurred in a complex social context.
CHAPTER 6: ETHICAL PROBLEM SOLVING WITHIN TWO DIFFERENT ORGANIZATIONAL CONTEXTS

This study involved interviews with nurses in two quite different Ontario hospitals: One was a community hospital in a smaller city, and the other was a large teaching hospital in a metropolitan centre. This chapter presents the organizational context within which the nurses carried out ethical decision making. That organizational context includes factors within the nursing unit and in the broader organizations: the nurses’ relational experience with the nurse manager and nursing colleagues on the nursing unit; relationships with others visiting the nursing unit, including physicians, patients’ families, and other health care providers; each organization’s history, location, size, complexity, resource allocation, and organizational roles and policies. What became clear in this study is that ethical problem solving occurred within a constellation of relationships on the nursing units and, to a lesser extent, within the broader organizations.

Within both organizations, the nurses’ ethical decision making and subsequent action were situated within this complex of social relationships. Participants in Organization A and Organization B described how aspects of their workplace, such as interpersonal relationships, power structures, and resource allocation, affected the nurses’ ability to work with patients and families in ways informed by caring values; develop relationships that were engaged, respectful, and effective; and resolve ethical problems with others. In this chapter, the discussion does not identify any of the participants, thus ensuring greater anonymity.
Case Study: Organization A

Organization A is a community general hospital in a smaller Ontario city. The hospital’s history includes some common characteristics of Ontario hospitals through the 1990s and the first decade of the 21st century: a merger of existing hospital boards, a reduction in overall bed numbers, and an eventual move to a new physical plant. Situated in a smaller city, the hospital has experienced difficulty attracting sufficient nurses and specialist physicians. The current bed number is between 300 and 450, including some tertiary services, and the organization had a less complex organizational chart than Organization B.

As a new hospital, Organization A, at the time of the study, seemed to be in the process of developing an organizational culture, or perhaps it was in the process of moving from several cultures brought from parts of other organization, to developing one organizational culture. This secular institution had yet to develop its own history and traditions. Furthermore, as a community hospital, Organization A had a relatively flat hierarchy of medical staff; for example, there were no medical student positions in the hospital and few levels of the medical hierarchy.

The participants described relationships with other individuals in the workplace, as well as the hospital as an organization, in terms of their impact on the nurses’ ethical problem solving. The nurses described how relationships with specific individuals or groups, as well as aspects of the organizational structure, influenced their ethical problem solving.
Role of the Physician

The participants described the role of the physicians in the nurses’ ethical problem solving in rather qualified ways. When asked about helpful relationships, most of the nurses indicated that their relationships with physicians tended not to be of assistance in resolving ethical problems. As 1 participant stated, “On a couple of instances, I’ve talked to the doctor, but they’re usually not as supportive as the nurse manager.” Another participant described the unresponsiveness of the physician when she pointed out that the physician was carrying out cardioversion procedures on patients who had received insufficient sedation:

Why aren’t we giving them enough so that they are sedated properly, and they don’t remember? So I brought that up, too, and you know, I don’t know what the facility is doing about it, because they just sort of, “Okay.” You could tell them [the physicians], but they’re the ones that are giving the treatment.

This nurse, who observed medical care that violated the best interests of patients, questioned why the organization had no mechanism to deal with inadequate medical care.

Nurses in Organization A reflected on changes that had taken place over the years related to the information available to patients and families about treatment choices. In one example, the nurse pointed out that a specialist physician on a nurse’s unit spent considerable time explaining proposed and possible treatments to patients and families, ensuring informed consent; the nurse reflected that this was in contrast with the absence of such information for patients she had cared for decades ago, earlier in her career. Other than this example, the participants generally described the role of physicians as less involved or uninvolved in the interactions undertaken by the nurses working through ethical concerns. In more than one of these instances, the nurses’ ethical problems arose directly from the physicians’ treatment of patients, treatment that the nurses viewed as
detrimental to the patients. Therefore, not only were the physicians unhelpful in resolving ethical issues but also in a number of cases, the nurses’ ethical problems arose out of the physicians’ behaviours, decisions, or care practices.

Role of Patients’ Families

When the participants described the unit as a setting in which ethical problems required resolution, several spoke of the lack of resources, such as time, privacy, and quiet space for discussion and other work with families. In one example, the nurse experienced tension among the need to provide complete patient care within the allotted time, the need to ensure that families were cared for, and the need to avoid others’ negative judgement for falling behind in care provision. The participant explained the conflict as one between providing the highest standard of care and caring for herself by having breaks, meals, and so on, versus submitting overtime requests. She commented on the implications for individual nurses of resolving such conflicts by providing care that was less than ideal to families:

If you do take the time to talk to the family (we all should be allowed to take that time to talk to the family), it puts you behind in the rest of your work. . . . then they say you’re disorganized or say you are not good at planning, you’re not good at this, you’re not good at that, because you have taken the time, so consequently, perhaps a lot of conversation with family is not done as well or as often as it should be done because of those things.

This nurse’s comments reflected how staffing levels, as set by organizational policy, had an impact on the resources available to the nurse in working through ethical problems, specifically, the availability of time, but also by inference the availability of others with whom to discuss ethical problems because those others also would experience time limitations. In addition to commenting on time constraints, the nurses identified a lack of privacy for discussions with families. The nurses saw an inability to provide
adequate time and space for work with families as affecting the quality of relationships that the nurses were able to establish and maintain with the families of patients.

*Role of Coworkers and Other Hospital Staff*

All five participants from Organization A described the importance of their relationships with their nurse manager and others providing care on the unit. The work relationships with other nurses, including the nurse manager, were among the most important supports for the participants as they considered ethical problems and decided whether or how to act.

Every participant mentioned the importance of a relationship with one key individual, the nurse manager, as being important to ethical problem solving. Two participants indicated that they would approach the nurse manager first: “I would probably go to [the nurse manager] in the beginning and sort of give her the heads up” [Participant]; “I would probably go to my nurse manager first” [Participant]. Two other participants also stated that they would speak to the nurse manager about an ethical issue: “I have spoken to [the nurse manager] many times” [Participant]; “Then we brought it to our manager’s attention, who brought it to the physician’s attention” [Participant]. A final participant indicated that in situations of insufficient staffing and concerns for patient safety, the nurse generally was able to depend upon the manager to respond in a helpful way:

> [O]ur manager is very good most of the time in that respect . . . . I know she was getting help in on a couple of nights because of that very thing, because it was unsafe, so we’re fortunate in that respect, that we have that kind of a relationship with our manager.

Therefore, all of the participants from Organization A spoke of their relationships with their nurse managers as an important interpersonal resource in ethical problem
solving. In each instance, the nurses named the manager as a first support, key resource, or valuable link to other resources. This finding indicates that relational space for ethical problem solving was present in the nurses’ relationships with their managers.

In addition to the nurse manager, these participants listed relationships with other nursing colleagues as important interpersonal resources in ethically problematic situations. One participant stated simply, “I'll go to colleagues.” Another participant described her own and other senior nurses’ responsibility to advocate not only for themselves but also for newer nurses. She said, “If they’re not going to advocate for themselves, you as a peer have to advocate almost for them.” In fact, all of the nurse participants at this hospital indicated in one way or another that they sometimes discussed ethical problems with their nursing colleagues, again reflecting the relational space for ethical problem solving present in these collegial interactions.

The nurses at Organization A saw nursing colleagues as possible relational resources; however, they also saw colleagues as sometimes obstructing their ethical problem solving. Therefore, some nurses were selective regarding whom they spoke with. One participant stated, “I like to talk to somebody who’s another nurse, who has a similar outlook as me and can give me some advice.” One of the nurses experienced obstruction by some colleagues as she advocated to the physician on behalf of a patient whom she believed had a serious complication; the nurse felt undermined by a colleague who dismissed the patient’s concern: “I had nurses that were opposing me, right up at the nursing station, right?” In that situation, the participant saw other nurses as undermining the nurse, who was working through an ethical dilemma by speaking up to advocate for the patient, instead of staying safely silent. This participant viewed opposition from
colleagues as extremely unhelpful, reflecting disengagement from the ethical problem and the absence of relational space for mutually respectful interaction among these nurses about the ethical problem. However, other than this instance, the participants from Organization A generally spoke of their relationships with nursing colleagues as positive resources for ethical problem solving.

When continuing to describe relationships with others that influenced their ethical decision making within Organization A, 4 of the participants also listed other care providers who attended on the nursing unit from time to time, including the discharge planner, social worker, clergy, and others. The nurses provided examples that described a range of hospital staff upon whom they could call for discussion and advice: “the discharge planner . . . a social worker . . . sometimes, the clergy: they’re very good just to visit, and just be part of that family conference too” [Participant]; “maybe pastoral care if it’s that kind of a case. . . utilization, social work, discharge planning” [Participant].

In one unit, a range of possible supports was available during regular interprofessional meetings: “We have meetings every morning – the physician, a nurse, RT, physio, dietician, so we do look at it as a team collaborative thing” [Participant]. The nurses’ relationships with a range of other care providers on the nursing unit provided interpersonal resources for discussion of ethical problems, consideration of alternatives, and work toward resolving those issues. However, the nurses did not identify any health care provider whose role it was to focus on ethical issues.

The nurses at Organization A saw the hospital’s clinical ethics committee as being quite unavailable to nurses working through ethical problems on the nursing unit. None of the nurses had brought an issue to that committee, nor did any of them mention its role
on their respective nursing units. One participant described why the nurses may have believed that approaching a clinical ethics committee was impractical and believed that clinical ethical resources on the unit provided more assistance:

Nursing does not have time, when there’s a situation on the floor, to get people together – the ethics committee or whatever – together to sit down with them and say, “Okay, now this is the case that we’re having a lot of difficulty with on the ward.” . . . and the way nursing runs, the workload, you can’t just pull off three people or two people or even that one nurse and sit down and have these big things, because then her work is backed up forever. . . . I think I wish there was more time in nursing days . . .

That participant situated ethical problem solving within the often conflicting demands on the nurse’s time and the difficulty finding the resources, including time and personnel, to deal effectively with ethical problems, particularly problems involving different needs and expectations of patients versus family members.

Overall, these participants described a relational context of their ethical problem solving in which the nurses’ relationship with the nurse manager was of key importance to working through ethical problems. The nurses also described their relationships with other nurses as being very important, notwithstanding the fact that other nurses could occasionally obstruct the nurses in ethical problem solving. Relationships with others who came to the nursing unit also were described by 4 of the 5 nurses as aiding the participants’ ethical decision making; those others included discharge planners, social workers, and the clergy.

All of these nurses worked through ethical problems in a context of relationships with the nurse manager, other nurses, and other care providers, as well as patients and family members. This finding suggests that these nurses experienced positive mutually respectful relationships with other workers with whom they could open relational space
in which to reflect on, consider, and work to resolve ethical problems. On the other hand, only one nurse provided an example of a physician as aiding the nurse’s problem resolution; it seemed that the physicians were less likely to engage in this type of relational practice with the nurses. Within this complex of social relationships, the nurses were able to discuss and work through ethical problems and consider possible alternative solutions, underlining the importance of how nurses’ ethical decision making is socially situated.

*Role of the Organizational Context*

These participants also identified aspects of the organizational context other than individual staff members as having an impact on ethical problem solving. The nurses spoke of clinical ethics committee and hospital policies as possibly facilitating ethical problem resolution, but they described lack of time, lack of privacy, and the values of administrators as aspects of the organization that could interfere with their ability to resolve ethical issues. These aspects of the hospital contributed to the context in which nurses worked out ethical difficulties. The following section includes a discussion of the role of these aspects of hospital structure in nurses’ experiences of support in resolving ethical problems.

Three participants recognized that the hospital had an ethics committee, 1 participant was uncertain, and 1 believed that the hospital did not have an ethics committee. Although some of the nurses perceived the ethics committee to be a potential ethical decision-making resource, none of them had used that committee. One participant described a situation in which she discontinued intrusive procedures ordered by the
physician that she viewed as medically futile without a medical directive. Reflecting that there she did not experience any repercussions for taking that action, she stated:

Well, had I gotten into trouble with it, I’m sure the ethics committee would’ve had at least an inquiry or meeting or something . . . . I’m sure I would’ve been a part of that. I’m sure my boss would’ve been a part of it too. It never came to that.

The comments about the clinical ethics committee were otherwise quite vague, indicating that that committee had a low profile in these nurses’ lives and that they did not use it. For example, 2 participants made quite vague comments about the committee: “And we don’t have committees where we meet once every six months or every two months, or stuff like that” [Participant]; “I think maybe if I had called the ethical committee, they would have given me an idea” [Participant]. One participant was unaware that the hospital had an ethics committee, and another was unsure, confirming the vague profile of the committee to these nurses.

None of these participants had actually used the clinical ethics committee as a resource, although some did express optimism that it might be helpful. One participant identified the structure of nursing work as a significant deterrent to working with an ethics committee to resolve ethical problems, and 2 of the 5 nurses were unaware of the existence of that committee. Therefore, it was apparent that the ethics committee was beyond the relational range of the participants and sometimes even beyond the knowledge of the nurses; clearly, the clinical ethics committee had little influence on the relational practice or experience of these nurses, nor did it seem to provide support to nurses in working through ethical problems. According to 1 participant, disinterest in involving the ethics committee in nurses’ ethical problem solving was the result of time constraints on nurses. There may have been other reasons for this disinterest.
In general, the nurses spoke much less about the organization beyond the nursing unit than about their experiences within their work area. Sometimes using specific examples, the nurses described aspects of the hospital as a whole in terms of their contribution to the nurse’s ethical problem solving. Hospital policies were cited by the nurses as aiding the nurses’ ethical decision making because they clarified issues, supported the nurses’ authority in fulfilling their role, and clarified the boundaries around powerful others’ authority. In this way, the policies clarified the relational authority of the nurses as representatives of the organization.

One participant described how police officers’ demands to interview patients created ethical problems for the nurses: “Ethically, you know, do you become a part of that? Do you sit on it, do you say no, they’re too sedated until they can have their lawyer present?” The nurse pointed out that a new hospital policy involving law enforcement officers’ access to patients helped to resolve such problems: “[W]e have certain protocols that we follow for that now, so it doesn’t happen quite as often . . . you just call the supervisor on evenings and they [police officers] must go through administration and they know that.” Policies of this sort helped to clarify roles and relationships between police officers and hospital caregivers in relation to hospitalized patients, giving nurses the relational authority to avoid betraying the trust in the nurse-patient relationship while avoiding obstructing officers of the peace.

Another participant described hospital policies as supports in reducing physicians’ verbal abuse of nurses, abuse that intimidated nurses and sometimes interfered with effective communication about patient care needs:

Yeah, verbal abuse is bad, and the hospital has zero tolerance for it. Anytime anything happens, we’re to write it up, and if it happens on evenings, we’re to let
the supervisor know. If it happens on nights, you’re to call the supervisor at home, and if [the nurse manager] is in the hospital during the day, you are to let her know immediately, and she gets on it immediately, and it has improved a lot. Again, a hospital policy limited negative physician communication patterns, patterns that the nurses described as undermining effective doctor-nurse relationships. In this case, the policy prevented specific types of disrespectful behaviour on the part of the more powerful physicians and helped to improve the relational practices within the organization.

The nurses sometimes experienced problems in reaching physicians to communicate information about the deteriorating conditions of some patients. One participant described a new organizational policy initiative designed to provide clinical decision-making support to nurses who were unable to elicit responses from patients’ physicians in situations of patient risk. She said, “[T]his new program that they have, where that team comes out of ICU to check on all the patients [who] are coming out of ICU for 24-48 hours – that is a wonderful thing that they’ve done.” Putting a policy in place ensuring the availability of physicians for patients removed the nurse’s concern that a patient’s worsening condition be dealt with appropriately, thus reducing relational conflict with the attending physician.

Policies focused on patients’ legal rights to informed consent were described by 1 participant as being absent earlier in her long career. That individual, recalling an ethically problematic situation that had occurred decades earlier, described the lack of emphasis on patients’ rights and the lack of sensitivity to patients’ legal consent requirements at that time as part of the ethical problem that she had experienced. The participant believed that the current emphasis on informed consent provides
organizational support to the nurse to ensure that patients have information about all options:

At that time, you see, things were different . . . . There wasn’t all of this informed consent like there is now . . . . [there had been greater risk for the nurse years ago] because you didn’t have so many people backing you up at that point in time either.

Decades earlier, the nurse had advised a patient and his family that he had choices about the extent of medical intervention for his health problem. Ambiguity around the role of nurses in ensuring that patients exercised informed consent made the participant feel vulnerable when ensuring that a patient was able to fulfill a wish for more information. At that time, the nurse had feared a negative response from powerful others in the organization because of her initiative with the patient; she had anticipated that she might have been told that she had taken to herself a right reserved for physicians, specifically that of offering alternatives to a patient related to medical treatment.

Several of the participants were able to point to organizational policies or practices that had helped them to avoid ethical problems. Policies regarding information disclosure to police about patients reduced the nurses’ ethical conflicts around the relational impact of such requests for information. Policies designed by the organization to reduce conflict between nurses and physicians were seen by 2 participants as aiding them in avoiding ethical problems and in providing patient care.

On the other hand, several participants distinguished between their perceptions of support at the level of the nursing unit and their perceptions of barriers or unsupportive behaviours on the part of the organization as a whole. The nurses at times became involved in patient care issues that also involved members of the hospital administration. For example, 1 participant recounted the circumstances following an incident in which
her patient had fallen and had been injured. The nurse felt that the organization had failed to provide the appropriate support to her in the legal proceedings that followed:

So they sued the hospital . . . and that poor woman . . . ended up dying 9 months later, and I got no support from the hospital at all, absolutely none . . . I was really disappointed by that, and I’ve never actually forgotten that.

That participant identified numerous relationships within the nursing unit that had aided her ethical problem solving. However, this nurse expressed uncertainty whether any relational resources beyond the unit level would be of assistance: “I would probably go to my superior first or talk to my colleagues but hospital-wise, no.” The nurse’s previous experience of the organization’s disengagement from problem solving may have influenced this nurse’s current trust in the broader organization to assist with ethical problem solving.

The nurses recognized that at times, conflict arose between their own ideals and the values that they believed the organization expressed. For example, 1 participant spoke extensively about the contrast between the values that she believed the organization should live by and the values that she saw expressed in her own lived experience within the hospital. That participant spoke critically of the senior administration of the organization, the decisions of the senior administrators, and the way in which those decisions affected nursing staff:

You look at who we have as leading in the nursing departments in the hospital and what their attitudes are, even to their own staff below them. It starts at the top – that attitude. That’s who is in charge of creating that attitude. . . . It’s a management problem. It comes from the top down. . . . but they should be ethically strong and they should have a strong ethics. . . . and they should have an ability to work with people below them in a way that empowers the people below them almost in a way where they’re making the people below them better than what they are. . . . Instead of stepping on people’s heads all the way across to stay high . . . It comes right down.
This participant’s frustration seemed to relate to a perceived disconnection between the values and attitudes of senior management and the patient-focused health-related values that she believed should permeate this supposedly health-enhancing organization. She articulated ways in which senior management had failed to meet her perceived standards of leadership in an ideal health care organization. Values noted by another participant in this study had to do with the organization’s secular nature:

[A]t this hospital, we don’t have a great pastoral team. Of course, there’s a difference between a Catholic hospital and a regular hospital. They just don’t have that same care, comfort and compassion component, and it’s too bad.

That nurse viewed her current hospital as less explicitly caring than one with a history of affiliation with a religious denomination. However, none of the other 4 participants mentioned the secular nature of Organization A as a support or a barrier to their ethical problem solving.

The powerful role of physicians in the hospital was commented on by several participants, indicating that the organization not only tolerated but also supported the unique autonomy and power of the medical staff. For example, a nurse decided not to intervene regarding a medical decision to carry out a procedure with insufficient analgesia for the patient, causing the patient unnecessary discomfort. The nurse pointed out the exceptional power of the medical staff: “They rule . . . . They want their own policies, and that becomes a part of it.”

The organization’s unwillingness to intervene when physician care harmed patients was seen as abetting this type of behaviour, leaving the nurse with a serious ethical problem and few options in terms of resolution. The participant observed that a different standard of behaviour seemed to exist for physicians and that the organization’s
creation of policy did not alone ensure that physicians’ care met the standards articulated by the organization. Therefore, the nurse perceived the relationship between individual physicians and the organization to be different from that experienced by individual nurses, for example. This assertion underlined the perceived power of physicians within the organization and perhaps the hospital’s unwillingness to act regarding substandard medical care. At the same time, several experienced nurses described themselves using approaches with the medical staff that included suggestions, discussion, confrontation, and the decision to ignore orders. The flat hierarchy of the medical staff resulted in bedside nurses relating directly with the specialist physician and, if problems arose, with the chief of the medical specialty or with the chief of staff. Therefore, ethically active nurses did have direct access to physician decision makers.

The nurses believed that decisions resulting in the scarcity of resources, including shortages of time and nursing staff, originated beyond the level of the individual nursing unit, and they saw this scarcity as a more general problem of nursing staffing in general. In addition, nurses spoke of their multiple relational responsibilities to patients, families, and the unit as a whole. The nurses described daily realities of the care situation, in which the nurses were required to apportion their time and energy carefully in different relationships, realizing that staffing seemed to be inadequate, to the point that absence from the unit for any breaks beyond meal times would upset the balance of staff to workload. One result of this rationing was to restrict the ability of the nurses to attend in-service events or ethics committee meetings, or to participate in the organization beyond the nursing unit.
Within the hospital, end-of-life decision making could become contentious, requiring the involvement of persons outside the nursing unit. One participant described the slow pace of such deliberations:

A week would go by, and then somebody would go on holidays. Another week would go by, then there’s a family conference, and somebody wasn’t sure and had to change it. . . . all these other things . . . can be a problem.

This nurse described delays in patient care caused by family members’ unavailability or uncertainty about decision choices. During all of this time, the nurse observed that the patient continued to suffer, being at the mercy of these complex and time-consuming relationships.

Ensuring the necessary privacy for families to deliberate over difficult situations of their loved ones constituted a real problem for nurses attempting to work with families around such decisions. One participant described a specific situation in which she had difficulty finding private space on the nursing unit for a family consultation.

It was a busy, busy, hectic day . . . and we were standing out in the hallway, and there’s stretchers going by, and there’s all kinds of noise, and clattering, and so on . . . . there was no place to get away from the hustle and the bustle, and the noise is horrendous, and the clattering of equipment, and the amount of people going by . . . . So all of those things are really hard.

Lack of private space to discuss ethical problems, confer with families, or create a more peaceful setting was seen as a problem in discussing and solving ethical problems as well as in maintaining effective relationships with patients’ families. A third nurse stated that participant’s difficulty more broadly by describing how the realities of business and the relentless task focus pressing on the nurse could distort caring values:

You know, the whole thing about organization is sometimes . . . it gets so big that it can turn into a toxic environment . . . the whole philosophy on caring . . . is lost because it just becomes a series of checklists and things to complete.
These nurses used general and specific examples to describe ways in which the realities of hospital structure and staffing, resource allocation, and lines of authority could mitigate against values-driven care, interfere with the development of effective relationships, and result at times in poor relational support for patients and families.

**Summary**

The nurse participants in Organization A described several aspects of the organization that had an impact on their ethical problem solving. It is clear that these nurses worked through ethical problems within a complex of relationships with the nurse manager and nursing colleagues; engaged, mutually respectful relationships with these individuals were considered the highest importance in creating relational space for ethical decision making. These socially situated interactions were pivotal in the nurses’ ethical decision making.

Relationships with other hospital personnel present on the nursing unit also comprised supports for some of these participants. With one exception, the nurses’ relationships with physicians seemed not to be helpful in working through ethical problems; however, the nurses did have ready access to the physicians to discuss their medical decisions. Hospital personnel who did not attend on the nursing unit also were not seen as helpful in ethical decision making. Although most of the participants were aware that the hospital had a clinical ethics committee, none of the participants had any experience with it. At least 1 participant viewed the ethics committee as unavailable to her because of nursing workload and time constraints; in fact, workload and time constraints seemed generally to constrain a range of interactions of the nurses beyond their unit.
Aspects of the hospital context other than individuals, for example, hospital policies, were viewed as sometimes helpful and sometimes detrimental to the nurses’ ethical actions: Although hospital policies helped to provide authority to the nurses interested in patient autonomy and protection of the patients’ best interests, staffing levels were seen by some of the participants as problematic. On the other hand, privacy, noise, and nursing workload could create problems for the nurses’ relational work with patients, families, and others, and thus compound ethical problems. The nurses mentioned a lack of privacy and quiet, for example, as a barrier to the development of the helping relationship with families in particular.

Case Study: Organization B

Organization B is a medical teaching hospital in a large Ontario city. The hospital’s history includes involvement with changes in Ontario hospital care during the 1990s and up to the present, including changes in specialized services offered at the hospital. Unlike Organization A, this hospital is affiliated with a religious denomination and has maintained its organizational identity intact for many decades. The current bed number is between 600 and 750, with an emphasis on secondary and, particularly, tertiary services. This hospital is located in a major metropolitan area, and there is no evidence of difficulty attracting either nursing or medical staff. As a major teaching hospital, this organization has greater complexity and a more substantial hierarchy than Organization A; as an example, it includes multiple levels of medical staff and leadership.

Participants in Organization B, like those in Organization A, provided their perceptions of their relationships with specific individuals and how they related with the hospital as an organization in relation to influences on ethical decision making and
problem solving. In Organization B, as in Organization A, the participants described the importance of relationships with individuals as well as organizational structure to the nurses as they engaged in ethical problem resolution.

*Role of the Physician*

Unlike the nurses from Organization A, 4 of the 5 nurses from Organization B described ways in which their relationships with at least some physicians included interactions around ethical decision making. All of these nurses also described ways in which some physicians’ behaviours were relationally problematic to the nurses in relation to ethical problem solving. The following examples provide evidence of the ways in which the nurses worked with the physicians in relation to solving ethical problems. They focused on the nurses’ confidence in relying on some physicians: “There was the doctors and social work” [Participant]; “It was good to talk to the physicians and my charge nurse” [Participant]; “Dr. B. and Dr. C., two of our ICU intensivists, are very in tune . . . and very approachable” [Participant]; “There is respect from all the doctors. Doctors respect the nurses” [Participant].

One participant saw the positive relationship as an important feature in communication and problem solving in the particular nursing unit:

I think in [current unit], the staff men that work respect the nurses, and the fact that we are at the bedside 24 hours a day and that if we feel that there is a problem or an issue with the patient that they will listen to us.

That participant described an example of a situation in which communication and problem solving among nurses and physicians was evident:

But everybody was trying to work together; and the doctors were saying, ‘Well, do you have any suggestions? Well, what about this?’ So I mean, everybody was working together to try to figure out how to help this mother understand.
Having relationships that allowed for such joint ethical problem solving was particularly important to that nurse. Four of the 5 participants from Organization B made positive comments about how their relationships with the medical staff assisted them in resolving ethical problems. Specific examples varied from comments about specific physicians to broad statements generally indicating that the nurses’ interactions with physicians were helpful.

Four participants also made comments indicating that some physicians’ behaviours could interfere with the development of relationships with effective communication and joint work to resolve ethical problems. Included in chapter 5 were examples of problematic physician behaviours provided by the participants from Organization B. The interactions between nurses and physicians in Organization B involved either engagement in respectful relationships and the creation of relational space for ethical problem solving or more disengaged, tense, and less respectful relationships that precluded that shared work, depending on the quality of the relationships possible with particular physicians. Unlike the nurses in Organization A, whose general experience involved a lack of physician participation in joint ethical problem solving, the nurses in Organization B experienced some physicians, but not all, as being very approachable. It is interesting to note that Organization B employed a clinical ethicist, whose presence on the unit may have drawn the nurses and physicians together to resolve ethical problems.

Organization B, a medical teaching facility, had a much deeper medical hierarchy as well as a transient population of medical students and resident physicians. On
occasion, the more hierarchical nature of the medical staff structure seemed to create distance between the bedside nurses and the medical specialists.

Role of Patients’ Families

Within this hospital, the nurses spoke of problematic relationships with patients’ families, particularly legally threatening approaches used by some family members. Organization B provided nursing staff with legal supports and assisted employees who were worried about legal threats made by family members of patients. For example, one nurse described an end-of-life situation in which a family member had communicated to staff in a legally threatening way. That participant commented that the hospital “had sessions with the lawyers in the hospital as well so that we knew where we stood – because I think people were worried that it was going to go to court.” This relational support may not have been directed toward assisting nurses with ethical problem solving, but it did nevertheless help the nurses to avoid focusing on legal threats as they worked through ethical problems in that situation.

The participants from Organization B, like those from Organization A, commented on the lack of space for private consultations with family members that interfered with the nurses’ relational work with the patients’ families. Unlike the nurses in Organization A, the nurses in Organization B did not express concern about the issue of time availability. One nurse in Organization B commented positively on the nurse-patient ratio in her unit and the consequent available time to spend with both patients and families in the ICU, where “the workload kind of came into play, that I had time to do that, you know? Like if I had two patients, I may not have had time to bother with that and it may have come across differently.”
Role of Coworkers and Other Hospital Staff

As in Organization A, these participants’ primary experience of the hospital as an organization was on their own nursing unit and in their relationships with those who provided care on it: the nurse manager; nursing colleagues; and others, such as the social worker. Four of the 5 participants indicated that their primary experience of the hospital’s administration was in their relationship with their nurse manager. One participant said simply, “I have an excellent boss. I’m very lucky. I think that she listens very well.”

Ways in which this nurse’s relationship with the nurse manager assisted the nurse working to resolve ethical problems included consultation, listening, discussion, and protection, as in the following example:

I think it’s important that in a situation of potential conflict, it’s good to have a manager that will back us most of the time and we’re not going to be thrown to the wolves by our immediate superior, which I hear from other staff. . . . my manager is extremely supportive and fair, so that support and fairness make it feel okay to take risks when I’m not sure I’m right.

The trusting relationship with the nurse manager created a supportive environment for nursing staff, according to that nurse. However, the relationship between the manager and the staff nurse could be less close and supportive, as one nurse indicated in the following example:

[I]t depends on your position in your unit and how familiar you are with the boss or how familiar your boss is with you. . . . Some are heard, and some are not. A boss hears what they want to hear from whom they want to hear it from – the boss sets the tone.

That participant, who had described a previous nurse manager’s poor quality leadership in another hospital setting, was able to compare and contrast nurses’ relationships with nurse managers, emphasizing the importance of being familiar with the
manager and recognizing that the relationship with the manager could vary from nurse to nurse.

Finally, the participants occasionally described very dramatic examples of poor leadership on the part of the nurse manager and ways in which that could undermine the trust of the nursing staff. In the following example, a participant recounted an experience on a previous unit and with a previous nurse manager, in which a patient’s family member behaved in a way that caused ethical problems for the nursing staff. In that situation, the pivotal role of the nurse manager was underlined:

The thing that made it a huge ethical problem was my manager . . . . She fed in to this woman, the wife, and all of her antics, and all of her drama, and all of her . . . everything that this woman wanted, our manager just fell into it.

By becoming associated with the family member’s problematic behaviour and decisions, that nurse manager undermined her relationship with nursing staff.

Together, these examples underlined the participants’ views that the nurse manager held a pivotal position in the nurses’ experience of the organization. The nurses also emphasized the role of the manager in helping them to resolve ethical problems. Although the participants in Organization B were able to provide examples of previous nurse managers whose behaviour interfered with the development of good relationships with nursing staff, these nurses, like those in Organization A, generally spoke positively about their relationship with their current nurse manager and how that relationship influenced the resolution of ethical problems.

In addition to the nurse manager, each participant from Organization B also mentioned other important relationships, including those with nursing colleagues and others. Several participants described the very positive interpersonal atmosphere in their
nursing unit. One nurse spoke directly to the issue of collegiality: “So nurses with the nurses, and nurses with other members of the team, relationships are pretty collegial.”

Another participant said:

[J]ust knowing that most of the people I work with are . . . pretty good people and . . . they generally respect how I feel about certain cases and give it the valid respect that it deserves whenever I bring up an issue.

The nurses in this study who had experienced less harmonious relationships with colleagues elsewhere contrasted this unit’s collegiality with those other experiences. For example, one participant spoke of teamwork: “When I went to [current unit], it was like a whole different world of nursing from where I was before . . . . the team works differently together.”

A second participant spoke of openness and, by inference, trust:

[W]e’re pretty open as a group . . . Not that I’ve had a great deal of experiences with other hospitals, but my other hospital in particular, they were very less open to each other. This group is really willing to be honest with each other, I think.

The positive relational behaviours of openness and honesty described here spoke to the positive collegial relationships enjoyed by the nurse.

Although these nurses described their current coworker relationships as having a very positive impact on their ethical problem solving, some declined to generalize this relationship to all nursing staff. For example, the nurses described some ethical problems arising from the actions of coworkers whose relational approaches tended to be intimidating or otherwise difficult; the nurses predicted that attempts to resolve those problems with the coworkers would have resulted in interpersonal conflict and a deterioration of the coworker relationship. The nurses saw the relational tone of those coworkers as reducing the likelihood that the participants would engage in interaction
with these nurses around their problematic behaviours or about ethical problems in general.

Although the participants described some coworkers as creating ethical problems, they also described relationship-building activities such as workshops and sessions on joint problem solving as ways in which the nurses’ interpersonal relationships fostered joint problem solving. One participant commented, “We have sessions on problem-solving. Like once a year we attend sessions on problem solving, communication, and working together. . . . It’s effective in our environment – our current work environment at [current hospital]. I find it effective.”

All of the participants spoke positively about the collegial relationships among nursing staff as a support to ethical decision making, but they also noted that some coworkers’ behaviours could create ethical problems. When the participants described ethical problems that they dealt with in their nursing practice, they also described relationships with others, in addition to nursing colleagues, as helpful. Within Organization B, a clinical ethicist was available to the participants on the nursing unit. Several participants described their relationships with the clinical ethicist as important to their ethical decision making: “[H]e’s awesome. This guy can make everything look black and white that looks all grey and mixed up” [Participant]; “I like having an ethicist around. I really appreciate it, even though I may not avail myself of him that much” [Participant]

The participants from Organization B valued their relationship with the clinical ethicist and credited it as helping them with ethical problem solving. One participant described the “debriefing” role held by the clinical ethicist in a specific problematic
patient care situation the nursing staff members were struggling with on a previous unit: “[S]taff in the unit were having a very difficult time with the whole situation and the way it was being dealt with . . . . There were debriefing sessions with the clinical ethicist in the hospital.”

The availability of the clinical ethicist in this hospital provided a contrast to the experience of some nurses in other hospitals. For example, 1 nurse who discussed another hospital that apparently had an ethics committee did not see that committee as a support in ethical problem solving:

It was a different hospital, so they had an ethics thing, but I didn’t know what it was or where it existed . . . . I think at that hospital, it was just that people were willing to say, “Yeah, we have an ethics committee.” It never really came into play.

The three participants in Organization B who mentioned their relationships with the clinical ethicist as being helpful to their ethical decision making described a number of ways in which that individual interacted with them to provide assistance: debriefing, listening, assisting with resolving ethical problems, and being available in case assistance is needed. In addition, 1 participant underlined how the physical presence of the ethicist contrasted with the absent, unknown ethics committee that failed to fulfill this function in the participant’s previous hospital.

The nurses did not find the unknown individuals on an ethics committee to be helpful; the nurses had no relationship with them, and they, the members of the ethics committee, did not attend on the nursing unit. On the other hand, they viewed the clinical ethicist, with whom they had developed a relationship, as providing direct and indirect assistance to the nurses on the unit as they worked through ethical issues together. The
two other participants at this organization did not specifically mention the clinical ethicist as a support in any way.

The clinical social worker comprised another support to nurses on the nursing unit, as was reported in Organization A. The relationship between the nurses and the social worker could contribute to ethical problem solving, as described by 1 participant: “It’s great . . . knowing that I don’t have to struggle with this on my own, that our social worker is awesome . . . We’re sort of on the same wave length, I guess.” The constellation of relational supports available to the nurse in resolving ethical problems was evident:

It wasn’t just one person that I went to for support. There was the doctors and social work, and in that case, I don’t know that I involved _____ [clinical ethicist], but knowing that he was there, too, has helped in the past with other things.

In this example, the multiple, layered relationships within which the nurses worked to resolve ethical problems included numerous individuals who had previously been predictable sources of support.

Similar to the nurses from Organization A, the nurses from Organization B commented on the array of individuals with whom they had developed relationships and with whom they could interact in order to explore and resolve ethical problems. In both organizations, the nurse manager held a key role in this regard. The nurses provided positive current examples of ways in which the nurse manager could help them to resolve ethical problems; they also commented on how problematic an unsupportive manager could be to ethical problem solving. The nurses’ relationships with nursing colleagues was seen as being very important to the nurses as they considered, discussed, and worked to resolve ethical concerns; however, as in Organization A, other nurses could be the
source of ethical problems and/or could obstruct the resolution of ethical problems. The nurses described these relationships as constituting aspects of the social context within which the nurses had to consider and resolve ethical problems.

Role of the Organizational Context

The participants from Organization B described aspects of the organization as a whole that could have an impact on the nurses’ ethical decision making. Factors included resources such as time and the physical layout of the nursing unit, especially its lack of privacy, the fact that the organization was affiliated with a religious denomination, and the layered hierarchy of this large medical teaching hospital.

Two participants mentioned the lack of privacy in the unit as a problem experienced in working toward the resolution of ethical problems. This lack of privacy hampered private discussions between and among professionals. For example, 1 participant decided against discussing a physician’s unsafe practice with the doctor, at least partly because of lack of privacy. The participant commented, “So, if I confronted him, the entire unit would know.” That participant believed that the lack of privacy might have impeded the nurse’s communication to the physician, communication that might have deterred the physician from an action that ultimately harmed a patient. The participant admitted that “it might’ve been easier to have confronted him if it were just he and I and the respiratory therapist perhaps.”

A lack of time to consider finding an alternative or to create greater privacy compounded the situation. In another example, a nurse mentioned the lack of privacy for nurses and families as reducing some options in terms of communication: “There are really poor options for providing family members with quiet time and privacy in what is a
difficult moment.” Participants in Organization A mentioned lack of space and lack of
time as problems encountered in their ethical problem solving. Both of these factors were
present in Organization B, although the nurses in that hospital emphasized the lack of
space.

Four participants commented on the organization beyond the level of the nursing
unit. Two participants mentioned the hospital’s religious affiliation. One participant saw
the hospital’s religious affiliation as influencing the way in which the hospital and its
decision makers might view some types of health problems. The participant believed that
it was possible that some members of the religious affiliation in the hospital might not
have viewed addiction problems as disease problems, but rather as spiritual ones:

Well, this hospital is a [religious denomination] hospital . . . . I don’t know that it
has any direct or indirect influence on this or any other ethical dilemmas. I think
[with] some ethical dilemmas that it does . . . . Maybe it does.

This participant believed that members of some religious denominations might
view attitudes toward problems such as alcoholism or drug addiction as faith issues rather
than health issues:

I think the health profession sometimes lags behind the rest of the world in
accepting . . . addiction . . . as a disease . . . . Does a [religious denomination]
hospital have more difficulty? Yeah, maybe, because . . . . they tend to see God as
the answer to things more than necessarily seeing it as a disease, maybe.

Another participant who mentioned that the hospital represented a religious
denomination was unable to describe how the religious affiliation would influence
nurses’ ethical problem solving: “It is a [religious denomination] hospital, and the values
of the hospital are influenced by that, but I don’t know specifically what the hospital’s
view of the situation would be.” These were the only two references to this hospital’s
religious affiliation, suggesting that the religious affiliation of the hospital was not
generally a factor considered by participants as particularly relevant to their ethical
decision making.

One participant from Organization A had suggested that that institution’s secular
nature might have had a negative influence on its support of caring values and ethical
conduct. At least 1 participant from Organization B suggested that that hospital’s
religious affiliation might have interfered with caregivers’ acceptance of alcohol and drug
addiction as disease processes; a second nurse from Organization B, despite indicating
that religious affiliation could have influenced values, was unable to describe how or to
what extent. These few comments conflicted somewhat and did not provide clear
statements about the role of a hospital’s religious affiliation in the staff nurses’ ethical
problem solving.

Some participants described Organization B as comprising a layered hierarchy in
the hospital administration generally and within the medical staff of the organization
specifically. For example, a patient’s wife used legally threatening approaches to demand
that the hospital prolong her husband’s life. One nurse believed that the physicians’
concerns about litigation influenced their decision to use extraordinary measures to
prolong the patient’s life for months: “They represent the hospital, and their fear for legal
action influenced my seeing this as an ethical problem.” The participant also expressed
difficulty in confidently describing a perspective of the organization as a whole, other
than as the decisions of the medical staff hierarchy:

I don’t know what the organization’s view is . . . . I mean, if we think of the
hospital . . . as a corporate individual, and if we think of the hospital as being
represented by the medical higher ups who are making decisions to continue with
this treatment, then, sure.
Other participants had also described how legally threatening behaviour on the part of patients’ families resulted in the nurses being directed by administrative and legal, as well as medical, staff, without input from the nursing staff. In such instances, the decision-making structure was described as failing to engage with the nurse caregivers in respectful relationships, as well as failing to consider the situations from ethical perspectives; this perceived lack of respect and ethical engagement left the nurses feeling marginalized, devalued, and silenced. The nurses also alluded to the hospital as hierarchical and lacking in collegiality in dealing with any ethically problematic situation that involved legal threats by a patient’s family members. One nurse perceived uncollegial interpersonal approaches as disempowering the nursing staff. This distant and faceless top-down approach caused considerable distress to this participant, devaluing the contribution of the nurses.

**Summary**

The participants from Organization B viewed engaged, mutually respectful relationships involving effective communication as being helpful in resolving ethical issues. Four of the 5 participants mentioned the nurses’ relationship with the nurse manager, and several spoke of relationships with nursing colleagues, the clinical ethicist, and physicians as supports. They also mentioned the generally positive relational tone of their nursing unit. They saw the availability of time as a positive resource in resolving issues with family members, but they implicated the lack of time in the nurses’ inability to prevent physicians’ errors; they also mentioned the lack of privacy as problematic. The nurses described the organization outside the nursing unit less uniformly. Two participants mentioned the religious affiliation of the hospital, although they did not agree
how this affiliation might influence ethical problem solving. Two nurses described the organization’s hierarchical nature, including a medical hierarchy, as an impediment to nurses’ ethical problem solving.

The discussion of Organizations B’s characteristics included the importance of relationships with the nurse manager; colleagues; and others, such as social workers, as well as the structural problem of lack of privacy for discussion with families and others. The nurses’ relationships with medical staff often focused on ethical problem solving. Organization B’s employment of a clinical ethicist comprised a significant resource for the nurses. These findings support the contention that nurses’ ethical problem solving is socially situated. The nurses from Organization B also commented on the hierarchical nature of the hospital and the medical staff, but none of them mentioned the role of hospital policy on their ethical problem solving. Finally, the nurses from Organization B spoke about the values of the broader organization or the religious or secular nature of the hospital; however, these comments tended to be more individual. The following comparison of the two organizations discusses all of these factors.

Comparison: Participants’ Perceptions of the Organizational Context

Organization A and Organization B are acute care hospitals in the same Canadian province, and both organizations are substantial in size. One has the attributes of a community hospital in a smaller city, and the other is a medical teaching hospital in a large city. There was a contrast between the two organizations in their ability to recruit and retain nurses and specialist physicians, with Organization A experiencing problems not encountered by Organization B. Participants in these organizations shared somewhat similar perceptions of the influence of the organizations on the nurses’ ethical problem
identification and solution selection. There also was evidence of differences between the two organizations’ influences, as reflected in the participants’ perceptions. The following discussion compares the two institutions using the organizers found in the conceptual framework, that is, nurses’ relationships with physicians, patients’ families, and coworkers, followed by a discussion of how each organization, its history, location, size, complexity, resource allocation, and its organizational roles and policies were important to the nurses’ ethical decision making.

Role of the Physician

The nurses described their relationships with physicians and the role of those relationships in their ethical problem solving as being negative and positive. Specifically, the nurses in both organizations spoke of ways in which their relationships with some physicians interfered with ethical decision making; those nurses referred to tense or intimidating communication on the part of some physicians as being problematic. Several nurses also described ethical problems as actually arising from the actions, words, or other behaviours of individual physicians. Although this problem has been documented in a broad range of nursing literature, the nurses did not see either organization as paying attention to this problem in terms of alleviating problematic physician behaviour or communication. Even when physicians’ clinical actions were the source of the nurses’ ethical concerns, the organizations seemed uninvolved.

Several nurses from Organization B also spoke positively about some of their relationships with physicians and the ways in which interactions between and among nurses and physicians helped to resolve these issues. Only 1 nurse from Organization A did so regarding a specific instance, describing ways in which a physician’s practice
behaviour worked to prevent ethical problems for the nurse around issues of informed consent, which was in contrast with those nurses’ generally negative views of physicians’ engagement in ethical problem solving. Therefore, it is not surprising that participants from Organization A indicated that physicians in general were less likely to be sought out than other professionals on the nursing unit as a source of support in ethical problem solving. At Organization B, the presence of a clinical ethicist may have altered the way in which nurses and physicians related to one another regarding ethical problems; it is possible that the ethicist was able to bring physicians into the discussions of ethical problems that the nurses from Organization A conducted without input from physicians.

Several participants from Organization A either described or alluded to more negative relationships with some physicians as deeper interpersonal impediments to nurses’ ethical problem solving. These poor relationships were a serious concern, particularly because this community hospital had no resident house staff upon whom the nurses could rely for advice or consultation; instead, the nurses were required to contact specialist physicians by telephone at all hours of the day and night; hence, the nurses were forced to rely on these specialist physicians. It is noteworthy that the hospital had difficulty recruiting medical specialists, and the hospital had found it necessary to institute a zero tolerance policy prohibiting abusive or harassing interpersonal interaction. This finding suggests that Organization A, although perhaps forced to tolerate a broader range of behaviour than one might see in hospitals sought out by specialist physicians for admitting and other privileges, had also experienced interpersonal difficulties serious enough to require a limiting policy. This policy provided nurses with an instrument to draw on the hospital bureaucratic hierarchy in order to intervene after the fact. One
participant indicated that instances of abusive or harassing communication by physicians directed at nurses had decreased substantially following implementation of the policy.

However, it is unclear whether this policy at Organization A had altered the underlying power differential or altered the culture of seemingly problematic communication between medical and nursing staff, characterized by physicians being disrespectful of nurses and disengaged from ethical problem solving. One other participant spoke of an initiative in which ICU physicians were available to nurses on other units, with the result that those nurses, although unable to contact attending physicians to communicate important patient information, could nonetheless speak with other physicians on behalf of patients. No other participant from Organization A spoke of other policies or programs focused on improving those relationships. Participants from Organization B did not speak of any hospital policy as an influence on nurse-physician relationships.

The relationships between some nurses and physicians from Organization B seemed to be much more collegial than those from Organization A. However, some nurses in Organization B spoke of the medical hierarchy as compounding ethical problems at times, indicating that members of the hospital hierarchy, far from the participants’ nursing units and patients and unknown to the nurses, made key clinical decisions. In particular, difficult end-of-life circumstances, such as when a patient’s family used legally threatening approaches with staff, seemed to be associated with decision making by the medical hierarchy outside the nursing unit and by individuals unavailable for discussion with the nursing staff.
The references to the hierarchical nature of Organization B contrasted somewhat with the discussion of the broader Organization A by its participants. There was the perception of a flatter medical hierarchy in the smaller community hospital, for example, in terms of the nurses’ very direct interactions with all physicians, and that feature of Organization A may have provided more opportunities for nursing staff to interact with the medical hierarchy more directly and possibly develop working relationships. Nonetheless, the participants from Organization B described their relationships with medical staff as being more functional, at least from the perspectives of these nurses. However, it did seem that the relationship between nurses and physicians was more positive in general for the participants from Organization B. The quality of relationships with physicians constituted an important aspect of the context within which nurses carried out ethical problem solving.

**Role of Patients’ Families**

The nurses from both organizations commented on the lack of private space available for them to establish relationships with families, discuss patient-related issues with them, provide information and support, and assist families with decision making. Several nurses from Organization A discussed time constraints as barriers to the development of relationships with families and provision of support and information. No nurses from Organization B discussed a lack of time to work with families, and 1 nurse spoke positively of the low nurse-patient ratio as a support to such work. Organizational differences in staffing ratios may have been present, although assessing staffing ratios and/or patient acuity levels was beyond the scope of this study.
Role of Coworkers and Other Hospital Staff

All 5 participants from Organization A, along with 4 of the 5 nurses from Organization B, described the pivotal nature of the nurses’ relationship with the unit nurse manager in the participants’ experience of the organization regarding ethical problems. Each of these individuals gave specific examples and offered general comments to articulate a view of the nurse manager as a key influence on whether and how they dealt with and/or resolved ethical problems. Participants described current and past nurse managers, often contrasting the effective relational behaviour of a current manager with the less effective or problematic relational behaviour of a past nurse manager, to illustrate the importance of this relationship to the nurses. The participants described how the nurse manager’s interpersonal approach helped with problem solving by being approachable and available not only to listen and offer alternatives but also at times becoming engaged in finding solutions in the form of policies and backing up staff so that they could make decisions and take action without a sense of unpredictability or high risk.

In Organization B, the participants credited the nurse manager with the creation of a positive interpersonal atmosphere within the unit, an atmosphere in which the participants trusted their manager to support them. On the other hand, managers whom the participants considered unhelpful had failed to engage in solution finding or had actually become part of the problem, as seen from the perspective of 1 participant. The manager who became embroiled in a dysfunctional relationship between a patient’s family member and the unit exemplified ways in which the manager could be seen as failing to provide relational support to nursing staff in dealing with ethical problems. It is
not surprising that the manager would have such a pivotal role in a rigidly bureaucratic organization because the manager would normally possess greater knowledge of the broader organization and the likely organizational response to various courses of action.

An experienced nurse manager, working with multiple nursing staff and focusing on a wide variety of issues over time, also would develop greater experience in considering a wide variety of ethical problems. The nurses’ consideration and resolution of ethical problems occurred within a context of which the relationship with the nurse manager was an important aspect. Finally, within the nursing hierarchy of the hospital, the nurse manager was a more powerful individual than the staff nurse, both from the perspectives of staff nurses and others.

Participants from both organizations spoke positively of their relationships with some nursing colleagues as an important resource in working through and resolving ethical problems. The interpersonal atmosphere of the unit was either clearly articulated or alluded to as supporting positive collegial relationships and, therefore, the participants’ proclivity to approach their nursing colleagues. Two participants from Organization B contrasted the positive interpersonal atmosphere of their current unit with previous experiences on other units, one in another hospital and one on another unit in Organization B. Although the participants spoke first of the nurse manager when asked about supportive relationships on the nursing unit, each also spoke of unit nursing colleagues as important supports. However, several nurses from both organizations described the problematic behaviours (e.g., substance abuse, care lapses, or verbal abuse of patients) of other nurses as creating ethical problems for the participants. One
participant provided an example of a nursing colleague attempting to obstruct her as she attempted to advocate on behalf of a patient.

It was not clear that there were any differences between the two hospitals regarding relationships among nursing colleagues. Participants’ comments on negative aspects of their relationships with coworkers suggested a subtext, namely, that the participants were reluctant to confront coworkers partly because of their fear of negative repercussions. Given the general concern in nursing related to interpersonal conflict between nurses and its impact on individual nurses as well as patients, it is possible that these nurses were working to reduce the risk of interpersonal conflict by avoiding confrontations in their coworker relationships. Although none of the nurses discussed horizontal violence or bullying by other nurses, several of them spoke about the risk of interpersonal aggression or even of the relationships ending if they confronted colleagues.

Nurses from both organizations spoke of a number of care providers who attended on the nursing unit from time to time. Several nurses from Organization A spoke about the social worker, utilization and discharge personnel, and clergy; some from Organization B spoke about the social worker and the clinical ethicist. Although the two groups of nurses similarly perceived other personnel as providing assistance with ethical problem solving, the presence of the clinical ethicist at Organization B, but not at Organization A, constituted a key difference between the two institutions.

Not only was the clinical ethicist regularly available on the unit to work with nursing staff who were dealing with particular ethical problems but that individual also conducted sessions of various types on a regular basis. Three of the 5 participants from Organization B described the clinical ethicist as a positive interpersonal resource in their
ethical problem resolution. One participant described the clinical ethicist’s debriefing sessions as helpful; that individual and two other participants spoke of their relationships with the clinical ethicist as being helpful in resolving ethical problems. One of those participants contrasted the tangibly supportive role of the clinical ethicist in the current work setting with the ineffectiveness of previously employing the hospital’s clinical ethics committee, an entity without any presence on the nursing unit and seemingly unavailable to assist with the nurses’ ethical problems.

In contrast, although Organization A had an ethics committee, only 3 of the participants from that hospital knew of its existence with certainty. Of the participants who were aware of the committee, 1 nurse spoke of the inaccessibility of ethics events and presentations, which occurred over the lunch hour and extended beyond the nurse’s lunch break. Two others described ethically problematic situations in which the ethics committee could conceivably have become involved, but did not, nor did the nurse approach the committee. Organization A’s relatively inaccessible, unavailable, and anonymous clinical ethics committee contrasted sharply with Organization B’s very local, immediate, and interpersonally active role of the clinical ethicist. The activities of the clinical ethicist, in drawing attention to and exploring the aspects of ethical problems of concern on the unit in Organization B, seemed to provide support to the nurses in reflecting on current ethical dilemmas.

It is possible that the presence of a clinical ethicist on the nursing unit in Organization B underlined the importance of ethical issues within that organization, thereby providing direct support to the nurses’ ethical sensitivity. That presence may have supported nurses and physicians in engaging in mutually respectful relationships
where they opened relational space to discuss ethical problems. It also may help to explain why the nurses from Organization B made more positive comments about the influence of their relationships with physicians on their ethical decision making.

Although this hypothesis was untested in this study, it is an interesting observation.

**Role of Organizational Context**

Organization A is a medium-sized community hospital in a smaller city, and Organization B is a large medical teaching hospital in a large metropolitan area. The larger teaching hospital’s hierarchy is more complex and layered; its medical hierarchy also is considerably more complex and layered. Organization B also employed a greater range of supportive personnel, such as a clinical ethicist. Organization A is a new secular institution, the result of an amalgamation of two previous hospitals; Organization B has a decades-long history as a hospital with a religious affiliation.

The participants from both organizations had difficulty finding examples of the organization beyond the level of the nursing unit as supports or barriers to ethical decision making. Three participants from Organization A described policies that resolved previous troubling ethical problems. On the other hand, 1 participant from each organization described members of the hospital hierarchy as acting out of fear of litigation at times rather than in the best interests of patients. Both of these participants saw this fear as a barrier to resolving ethical problems. One participant had the sense that these participants’ relationships with members of the hospital administration were poorly developed.

Three nurses discussed the absence of a religious affiliation in one hospital and its presence in the other. However, although the individual from the secular hospital
believed its caring values to be less developed than that nurse had experienced at a
religiously affiliated institution, neither nurse from the religiously affiliated hospital was
able to articulate such a clear connection. In fact, one of the nurses from Organization B
surmised that the religious values of the organization might have interfered with the
hospital viewing certain patients’ behaviours as health problems rather than character
flaws. The other individual believed that the religious affiliation of the workplace and the
related values could have affected the way in which ethical problems were resolved, but
that participant was at a loss to define the views of the organization as an entity.
Therefore, there is little clear evidence related to participants’ views of the role of
religious affiliation in explaining the characteristics of the organizations.

Relationships developed by the nurses with patients, managers, coworkers, and
others were critically important in their ethical problem solving; in fact, they constituted
the context within which problem solving occurred. Working within rigidly hierarchical
organizations, these nurses experienced the workplace from within the nursing unit,
where they were able to develop important relationships and interact with other
individuals. The quality of their relationships seemed to influence the extent to which
they could explore and clarify issues, find common ground, and identify alternatives.
Relationships also were helpful to the nurses in assessing the risks inherent in particular
alternatives, although there often was ambiguity around the likely outcomes of particular
actions. This ambiguity was problematic because the nurses sometimes abandoned ethical
interventions after encountering initial resistance, unsure of the risks involved in further
interventions. In some situations, nurses who feared the marginalization that could have
followed their ethical intervention decided to self-silence out of fear of that risk.
Although both hospitals had made some investment in resources for ethical problem solving, in one, an ethics committee, and in the other, a clinical ethicist on the nursing unit, the nurses still experienced difficulty acting on their ethical decisions.

**Conclusion**

Organization A and Organization B, although similar in many ways, displayed a number of important differences. Organization B is a large teaching hospital in a metropolitan centre, and it has a more layered medical hierarchy and employs a clinical ethicist. Organization A is a medium-sized community hospital in a smaller city that seems to have a much flatter hierarchy and does not have an ethicist. Organization B represents a religious denomination, although the importance of that fact to the findings of this study, was unclear.

The relationships between the nurses and the broader organization reflected poor development in relation to ethical problem solving, and the nurses’ primary experience of these two organizations was on their respective nursing units. In that nursing unit setting, the nurses had opportunities to develop a wide range of relationships with the nurse manager, others working on the nursing unit, and others visiting the unit. Although the relationships between nurses and physicians could be positive or negative in both organizations, the participants from Organization B spoke much more positively about their relationships with at least some physicians in terms of ethical problem solving; the participants from Organization A generally found physicians to be uninvolved in such decision making. Therefore, although Organization B had a more complex and layered medical hierarchy, the participants from that hospital spoke of joint ethical problem solving and positive relationships with at least some of the physicians.
The participants from both hospitals spoke with unity about four factors. They emphasized the key role of nurses’ relationships with the nurse manager in nurses’ attempts to resolve ethical problems. The nurses also discussed the importance of relationships with nursing colleagues as a support in that process. They mentioned the array of others visiting the nursing unit who could provide interpersonal support. Lastly, they commented on the importance of the nursing unit level of the organization to the nurses’ attempts to resolve ethical problems. Notwithstanding the support offered by nursing colleagues, the nurses mentioned instances in which coworkers interfered with the nurses’ ethical problem solving or were the source of the nurses’ ethical problems either by failing to provide adequate nursing care or by engaging in other problematic behaviours. Within the nursing unit, nurses spoke of caution in confronting other care providers because they did not wish to harm others as well as their concern about possible responses, including potential damage to relationships.

Beyond the level of the nursing unit, the participants were less specific. The participants from Organization B gave the impression of not having relationships with decision makers in the administrative or medical hierarchy. The nurses spoke of resource decisions such as those around staffing, the lack of privacy on the nursing unit, and other issues, as having an impact on the nurses’ ethical problem solving. Participants from Organization A cited hospital-wide policies as possible influences on the nurses’ ability to work through and resolve ethical issues.

The organizational context for the nurses’ ethical problem solving within a rather rigidly hierarchical setting included access on the nursing unit to key relationships, for example, with the nurse manager; colleagues; and in Organization B, with the clinical
The nurses sought to maintain positive relationships with others in what were sometimes tense and difficult interactions. In addition, the pervasive power of the physicians and the medical hierarchy had a direct influence on these nurses’ ethical problem solving; although numerous ethical problems arose from physicians’ behaviours, an issue documented in previous studies, there was little action on the part of either organization to ameliorate these problems. The nurses from Organization A saw the presence of hospital policies as increasing the nurses’ authority and protecting nurses from physician abuse, respectively. The nurses saw the policies as having a positive effect, but in the latter case, they dealt with problems only after the fact. The nurses from Organization B gave the impression that although it was a more complex organization with a deeper hierarchy than Organization B, perhaps it used resources more effectively to foster effective working relationships and reflection on ethical issues.

At the same time, several nurses from Organization A commented that by virtue of their long experience with that hospital and its predecessors, they were able to resolve ethical problems by using the resources available and exercising judgement acquired over long careers. Within the hospital context, the factors that helped the nurses to deal with ethical problems included their relationships with others, such as the nurse manager; coworkers on the nursing unit; and others who attended on the nursing unit, such as the social worker, clergy, and clinical ethicist; and at times in Organization B, physicians.

These findings underline the multiple ways in which nurses’ ethical problem solving occurs within a complex of social relationships. In addition, hospital policies and staffing levels in some areas such as ICU could provide resources useful in resolving ethical conflicts. Barriers to ethical problem solving were identified as the rigidly
hierarchical nature of the hospital; the authority and power of the physician in comparison with those of the nurse; the potential for and the impact of interpersonal conflict between and among nurses; the lack of power; and the lack of resources such as time, privacy, and staff.
CHAPTER 7: DISCUSSION OF THE NURSES’ ETHICAL DECISION MAKING
WITHIN A RELATIONAL ETHICAL PERSPECTIVE

This study sought to explore the experiences of nurses in ethical problem solving. Specifically, the study sought to answer six questions:

1. What are the values expressed by the nurses?
2. What situations present ethical problems for nurses?
3. What is it that makes such situations problems?
4. How does the nurse act upon such problems?
5. What are the things that help the nurse in dealing with ethical problems?
6. What are the things that hinder the nurse in dealing with ethical problems?

What became evident in this study was that the nurses valued protecting the rights and wishes of their patients and bringing about the best outcomes for them. They valued their relationships with patients and others through which they could achieve the best outcomes for patients. It was clear that the nurses’ ethical problem solving and subsequent actions occurred within a complex social context. Finally, the nurses valued avoiding harm to others, whether through their own or others’ behaviours. These nurses indicated that their considerable clinical experience, knowledge, and confidence informed their ethical actions. The situations that these nurses recounted as being ethically problematic were those in which the patients’ wishes, rights, and/or best interests were violated or threatened, whether by physicians, the patients’ family members, or the nurses’ coworkers. The nurses’ actions ranged from doing nothing to suggesting, discussing, persuading, confronting, reporting, subverting, and even ignoring medical orders.
What helped the nurses to deal with ethical problems included knowing the wishes of patients; engaging in interpersonal interactions with the nurse manager, coworkers, and others; understanding hospital policies; and having adequate staffing and other resources. The nurses were hindered in their ethical problem solving by disrespectful, tense, or poor interpersonal relationships with physicians, families, or coworkers; fear of retaliation or withdrawal of good will; lack of such resources as time, privacy, or staffing; and a rigidly hierarchical organizational and power structure. In the complex of interpersonal relationships that characterized the hospital nursing unit, these nurses sought to bring about the best outcomes for patients while maintaining relationships with others and avoiding harm to themselves or others. The nurses experienced the organization primarily as a complex of interpersonal relationships within which ethical decision making and action occurred.

The researcher used a relational ethics lens to consider how these relationships influenced the nurses’ ethical problem solving. The themes of mutual respect, relational engagement, relational or ethical space, embodiment, and ethical environment allowed the investigator to consider the narratives of the participants. Included in this chapter is a discussion of the results and their relevance to this emerging health ethics theory. The focus of the discussion is the nurses’ concern for patients; the role of their professional experience; and their contextual appreciation of layered relationships with patients, physicians, families, and coworkers.

**Mutual Respect**

According to Bergum and Dossetor (2004), mutual respect is a key theme in relational ethics, conveying the notion of respect as “worth or worthiness” (p. 68) and
mutual as “interactive or reciprocal” (p. 68), and is seen as occurring within “an atmosphere of interdependence” (p. 69). This concept focuses attention on how individuals deal with difference, particularly when there is disagreement with others’ actions or decisions. According to Bergum and Dossetor, respect for others transcends differentials of power, knowledge, gender, culture, and so on, and is not only a foundational aspect of relational ethics but also one of the most difficult concepts to bring into being. Bergum (2004) pointed out the importance of the role of the nurse in bringing about effective teamwork, noting that “the nurse has the tough, and often thorny, job of assisting all members to work in collaboration rather than in hierarchical pockets – a responsibility that cannot be the nurse’s alone.” (p. 495). Bergum further emphasized the importance of effective team functioning in health care for ethical problem solving to occur by stating that “if mutual respect is the central challenge of relational ethics, then teamwork is the prime opportunity for relational action.” (p. 495).

The participants in this study emphasized the importance of knowing and following their patients’ wishes as well as avoiding violating the patients’ rights. Participant 8 clearly articulated the importance of maintaining openness to the perspective of others, especially the patient. This nurse pointed out the importance of being open to the other person’s perspective in order to discern the needs and wishes of the other person; the participant also articulated the concern of nurses regarding the need to respect patients.

I have a tendency to . . . be able to see all sides of a situation . . . so I tend to approach such situations with a great deal of respect and within reason, given the information that I have, with an ability to see the point of view of all the people concerned . . . either because they are the patient lying in the bed or because they are family members who are potentially overwhelmed with what’s happening to
their loved ones and don’t have a lot of ability to sift through the information that they are given, both from lack of exposure and from the stress that they’re under.

Participant 2 spoke about the need for self-monitoring and reflection in ensuring that patients whose lifestyles are different from those of the nurse would not experience judgemental or discriminatory behaviour on the part of the nurse:

What if it was some [person] from ____ Street that was a booze hound for 30 years? Would that have made a difference? . . . . I am going to really hope that it wouldn’t make a difference to me.

Ensuring that patients received respectful treatment, regardless of the patients’ own behaviours or values, was a priority for this nurse, and other participants also spoke of the need to respect their patients’ wishes and rights. This nurse, however, spoke frankly about the challenge one could experience in ensuring equal respect for all people, underlining the very deliberate interpersonal approach used by the nurses. Most of the nurses in this study expressed concern about their relationships with some physician colleagues. One of the organizations had instituted a policy to curtail abusive physician communication directed toward others. Physicians’ behaviours are sources of nurses’ ethical problems that have been particularly well-documented by past researchers (Åström et al., 1995; Enes & de Vries, 2004; Erlen & Sereika, 1997; Hutchinson, 1990; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Sleutel, 2000; Sundin-Huard & Fahy, 1999; Woods, 1999).

In 2008, the College of Physicians and Surgeons of Ontario published a new policy describing disruptive behaviours by physicians and outlining the responsibility of doctors to patients; other health care providers; and the profession to avoid disruptive behaviours, including words and actions. The publication of this document indicated that Organization A is not the only hospital in Ontario that has experienced problems with
disruptive behaviours by physicians. Redman and Fry (2000) found that tension between nurses and physicians can reduce the ability of nurses’ to resolve ethical problems, a finding consistent with those of this study. The nurses in the current study described physicians’ behaviours as leaving nurses feeling disrespected, sometimes silenced, and with few alternatives other than to tolerate such behaviours. These nurses were acutely aware of the power differential between themselves and the physicians. Physician-nurse relationships characterized by conflict, disrespect, and dismissive behaviour are antithetical to mutual respect or even to effective interpersonal interactions, and they reduce the likelihood that the nurses who are the recipients of such behaviours would attempt to engage with the physicians around ethical problems.

Relational Engagement

Relational engagement is an important concept in relational ethics. Through relational engagement, nurses and patients can connect in ways that find meaning. The emphasis on relational engagement acknowledges the tendency within the medical model of health care to view patients as a set of symptoms, the failure of a particular organ, or the site of disease. However, nurses aspire to a holistic view of the patients in their care, a view that takes into account the whole experience of patients of the illness.

In the case of a sudden illness or end-of-life circumstance, Bergum and Dossetor (2005) described relational engagement as “a way to make meaning out of a tragic experience” (p. 110). By relating to each other as people, nurses and patients could better understand each other (Bergum & Dossetor, 2005). All of the participants spoke about focusing on the needs, wishes, or best interests of patients, reflecting relational engagement as one way in which the nurses’ ethical sensitivity was socially mediated, a
result also found in other studies (Erlen & Sereika, 1997; Fry et al., 2002; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Wurzbach, 1999).

It was through the nurses’ close interactions with patients and their families that they were able to discern the patients’ wishes. The participants discussed the importance of knowing patients and understanding their perspectives. As Participant 1 pointed out, “We have to understand why they are the way they are and you need to walk a mile in their shoes.” By actively working to understand and empathize with the patients, the nurses believed that they could achieve knowledge of them. The nurse participants consistently described themselves as respecting the patients’ known wishes.

When the focus of an acute care hospital is on the care of people experiencing illness episodes, it is all too easy for the care of those people to become depersonalized. By engaging with patients, these nurses were able to see their uniqueness. Participant 5 stated simply, “I think personally just remembering that there’s a person there” formed an approach that the participants used to engage with their patients as people. The nurses’ relational engagement also extended to other health care providers, including coworkers, nurse managers, and physicians, again reflecting the socially contextual nature of the nurses’ ethical problem solving.

Embodiment

According to researchers describing a relational ethical approach, the concept of embodiment reflects an advance beyond the mind-body disconnection of enlightenment philosophy toward

Healing the split between mind and body – an integrative consciousness . . . so that scientific knowledge and human compassion are given equal weight and so that emotion and feeling are as important to human life as physical signs and symptoms. (Bergum, 2004, p. 492)
This postmodern reconnection of mind and body allows health care providers to be attentive to each patient’s life as it is lived. In this way, nurses or physicians are aware of the inherent unique wholeness of each person, even in patients for whom death is imminent. In relation to dying patients, Participant 10 alluded to this unique wholeness as she reflected on the totality of the person experiencing a life-threatening illness: “[E]very case is not the same . . . . it depends on how they live their lives as to how they’re going to be living their death.” Engaging with patients opens the possibility of embodiment, that is, knowing each person as a whole rather than a person with a physical malady; allowing nurses to better understand how patients as persons lived their lives; and in the case of dying patients, understanding how they can assist them to live their deaths. Attention to embodiment means honouring feelings and thoughts rather than dismissing ethical deliberation that has an emotional component.

Ethical Environment

From a relational ethics perspective, the environment is comprised of people who make up the environment “in here,” not something “out there” (Bergum, 2004, p. 489). Reflecting Gadamer’s discussion of the relationship between motives to live well for others as well as oneself, Bergum stated, “We can only live well autonomously if we live well together” (p. 491). The theme of people as the environment, which is important in relational ethics, was a key theme in this study, which focused on nurses’ reflections on their attempts to resolve ethical problems with others, including patients, patients’ families, physicians, coworkers, and others within the environment of the individual nursing unit. These nurses found that people comprising the environment could constitute supports or barriers to ethical problem solving. The socially prescribed roles of nurses
and others within that environment also influenced ethical problem solving, sometimes contributing to the nurses’ experience of risk in ethical problem solving.

Several nurses described as “crossing the line” or “going beyond my boundaries,” actions that they deemed necessary to resolve ethical problems and to bring about better outcomes for patients. Most of these behaviours involved extending their authority into areas traditionally reserved for physicians: giving advice or information to patients and families that traditionally would come from physicians, confronting physicians about diagnostic or treatment decisions, or ignoring physicians’ orders. Other nurses, aware of what should happen to or for patient, but who were unwilling to risk usurping the physicians’ authority, experienced moral distress because they were unable to resolve specific ethical problems. All of these findings reveal ways in which the nurses, their ethical decisions, and their ethical actions were socially situated. The next section discusses the results of this study in light of the conceptual framework.

Concern for the Patient

The researcher changed the conceptual framework for this study following analysis of the data to reflect the emphasis on the relationships revealed in the study. The investigator used a relational ethics lens to consider the results of the study, including the key relational ethics themes of mutual respect, relational engagement, embodiment, and ethical environment. The original conceptual framework had depicted the patients as the nurses’ primary concern based upon a review of nursing codes of ethics and other literature. The participants confirmed this depiction: Each described the importance of patients as their first concern and indicated ways in which they expressed that concern.
This finding is consistent with those of other studies (Erlen & Sereika, 1997; Fry et al., 2002; Lützen & Schreiber, 1998; Redman & Fry, 2000; Wurzbach, 1999).

The nurses engaged directly with patients who were able to express their wishes, seeking to know those wishes, showing respect for them, and conveying them to other care providers. As the care providers with the greatest access to and time spent with patients, these nurses were in a good position to ascertain the perspectives and wishes of the patients. Based upon their professional knowledge and experience, the nurses inferred the best interests or best outcomes for patients unable to express their wishes. The nurses’ ethical sensitivity to their patients was deeply relational.

Nursing Experience

The participants described themselves as drawing on their professional nursing experience in numerous ways as they identified and worked to resolve ethical problems. Several nurses indicated that they would not have recognized the key clinical features of specific ethical problems at earlier stages of their careers. Although a few nurses described their upbringings or religious values as contributing to their ethical sensitivity, they all identified their professional nursing experience as contributing to their ability to identify ethical problems. Their nursing experience informed their commitment to resolving problems for patients and provided them with information on possible courses of action. This finding is consistent with that of other researchers (Benner et al., 1996; Erlen & Sereika, 1997; B. Kelly, 1998; C. Kelly, 1998). Furthermore, other researchers have linked professional experience and ethical development (Lorensen et al., 2003; Woods, 1999; Wurzbach, 1999).
The Nurses’ Layered Relationships

The conceptual framework for this study depicted the nurses identifying, deliberating on, and choosing whether and how to act on ethical problems in their nursing practice within a constellation of relationships. Indeed, the participants described their work as involving patients, families, the nurse manager, coworkers, physicians, other health care providers, and the organization itself. Others have noted this constellation of relationships, and Rodney (as cited in Rodney, Brown, & Liaschenko, 2004) gave the term relational matrix to the “connectedness and interdependence of individuals working in relationship with one another in an organizational context” (p. 164). Varcoe et al. (2004) provided an elaboration of this concept, acknowledging nurses seeking to resolve ethical problems as being “historical, social and contextually situated” (p. 323).

All of the nurses indicated that they engaged with many others in attempting to resolve ethical problems, pointing to the deeply social nature of nurses’ ethical decision making. By seeking the patients’ perspectives, the nurses ensured that they did not impose their own wishes on patients, but supported the patients’ decision-making power instead. Most of the nurses used the word “advocate” to describe themselves as seeking to bring about patients’ wishes or best outcomes. Within that role, the nurses worked to engage with many others in addition to patients, seeking to open relational space to consider and reflect together on ethical problems: patients’ families; nurse manager; coworkers; and other members of the care team, including the physician, and in the case of Organization B, the clinical ethicist.

Most of the nurses described their relationship with the nurse manager as of critical importance as they worked through ethical problems. Some nurses described the
nurse manager as providing a sounding board and, at times, an alternate view, providing evidence of the mutual respect, relational engagement, and use of relational space indicated in the emerging relational ethics theory. Almost all of the participants identified coworkers as being just slightly less important sources of support than the nurse manager; with coworkers, the participants could discuss ethical problems; consider alternatives, including intended and unintended outcomes; and analyze options.

The participants also worked with others who attended on the nursing unit, including social workers, discharge planners, and members of the clergy. In the case of Organization B, the clinical ethicist constituted a significant resource for the nurses in resolving ethical problems, depending on availability. The nurses from Organization A indicated that the physicians rarely entered into such interactions related to ethical problems, suggesting disengagement from ethical deliberation. The nurses from Organization B had the experience of some physicians participating along with other members of the care team. Within this relational milieu, the participants were able to engage with some others by opening relational space for ethical problem analysis and solution. However, they also were constrained from many ethical actions by the power differential that they experienced with physicians, the limited authority of the staff nurse, the legal power of family members with power of attorney, and the relational tension underlying the risks inherent in confronting others whose behaviours had created ethical problems. With the benefit of professional experience, these nurses carried out a situational analysis of the immediate context and, within a complex social context, ascertained the probable outcomes of various possible alternative solutions to their ethical
problems; they used clinical knowledge and information gained about the organization and the relationships within it to assess the risks or possibilities in various options.

Nurses and Physicians

The nursing research literature has extensively documented problematic relationships between nurses and physicians, and the impact of those relationships on nurses’ ethical decision making. One source of difficulty for nurses that has been reported widely in the literature is the power differential between nurses and physicians (Ahern & McDonald, 2002; Lützen & Scheiber, 1998; Redman & Fry, 2000; Sleutel, 2000; van der Arend & van den Hurk, 1999). This power differential, which pervades all nurse-physician interactions, is multilayered in itself and involves not only individual practitioners but also the respective occupational structures within the hospital, scope of practice legislation, and social norms in which physicians can be argued to occupy one of the most socially privileged positions of any profession.

Although traditional male and female sex roles may explain some of the origin of the power differential between nurses and physicians, the dominant position of the medical profession is itself multilayered and involves structural support for medicine by government, legislation, and educational systems, as well as pharmaceutical and other businesses and research funders (Peter, 2000). The pervasiveness of this power differential is an important aspect of the social context within which the nurses worked to resolve ethical problems.

Malloy et al. (2009) compared the power differential between nurses and physicians across four countries and found that this differential is the norm both in Canada and in other countries. A 1990 study of nurse-physician relationships in U.S.
hospitals was cited by and replicated by Sirota in 2007, with the results indicating that the relationships had changed only slightly in 17 years; in 2007, American nurses continued to perceive poor communication, a lack of respect for their input, and a feeling of being ignored by physicians. Participants in the U.S. study also noted that their employers continued to tolerate problematic behaviours by physicians.

In the current study, the participants’ perceptions seemed similar to those of the nurses in those two studies, reflecting the perception that physician privilege was deeply entrenched in their workplaces. These social beliefs, practice acts, and organizational structures constituted important aspects of the social context and organizational processes that interfere with the nurses’ ethical actions on behalf of patients. This was true even in situations in which the nurses sought to prevent other care providers from harming patients. All of the participants indicated that problematic relationships existed with some of the physicians with whom the nurses worked, and several nurses gave examples of serious problems in their professional communication with some physicians that included shouting, swearing, name calling, and other intimidating behaviours. From a relational perspective, these behaviours were indicative of a profound lack of respect for nurses demonstrated by certain physicians, severely reducing the likelihood of relational engagement and the creation of relational space in order to resolve ethical issues.

Although the nurses from Organization B described some physicians as participating in ethical problem solving, this was not the case at Organization A, suggesting the disengagement and unavailability of physicians for shared ethical deliberations. The participants noted or anticipated very difficult ethical problems, in which physicians’ errors, omissions, or lack of skill harmed or could have harmed
patients. Other researchers also have noted ethical problems reported by nurses that have been the result of care lapses or the other actions of physicians (Åström et al., 1995; Enes & de Vries, 2004; Erlen & Sereika, 1997; Hutchinson, 1990; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Sleutel, 2000; Sundin-Huard & Fahy, 1999; Varcoe et al., 2004; Woods, 1999).

The nurses then had to decide whether and how to intervene, recognizing the considerable risk to themselves in so doing because of the nurse-physician power imbalance. The nurses approached such situations in various ways, depending on the particulars of a case, the nurses’ skills, and the time available. Ranging from doing nothing to confronting physicians or ignoring physicians’ orders, these nurses analyzed the social situations to consider a range of relational strategies, including requesting, negotiating, confronting, and disregarding orders in order to bring about the patients’ best outcomes.

Nurses and Decisions Made by Patients’ Families and Physicians

The nurses experienced distress when the decisions of others, whether family members, physicians, or others in the organization, undermined their patients’ rights or best interests. Power of attorney and other legal instruments conferred on family members powerful legal rights in making health care decisions for their loved ones; the participants perceived that this situation caused physicians and the hospital hierarchy to defer to family members holding such rights, disengaging from the attendant ethical problems when patients’ wishes were disregarded.

These nurses sought to engage with those families in an effort to open relational space to consider issues related to patients’ wishes or best interests. Seeking to maintain
mutually respectful relationships with family members, these nurses experienced great frustration when patients’ family members seemed to focus on their own needs rather than those of the patients. The nurses conferred with the nurse manager, nursing coworkers, and other health care providers, and they interacted with family members by trying to ensure a focus on the needs of patients and working within this social context to resolve ethical problems.

In this regard, several nurses from Organization A described the fine line that they walked in working to influence family members to focus on patients’ needs. This fine line referred to the risk to the nurses involved in this type of advocacy, namely, the risk of criticism from the physicians, others in the organization, and possibly the patients’ family members, for having stepped over an invisible line around a nursing scope of influence as it is perceived by others. The fact that so many participants used this analogy indicated a widespread concern. However, there also seemed to be considerable ambiguity around where the fine line actually was, indicating that it was unclear or unstable in certain contexts. As these nurses carried out situational analyses of the social risks of particular actions under consideration, the issue of the fine line seemed to come into play in different ways, constituting a shifting and ambiguous social context.

Considerable difficulty also arose for the participants in circumstances in which patients were unable to communicate their wishes and have them carried out. The nurses expressed anguish at having to participate in extending for weeks or months the lives of comatose patients at the behest of family members supported at least instrumentally by physicians and sometimes the hospital administration. These decision makers created treatment plans that the nurses believed to be excessive because they prolonged suffering
and violated the patients’ rights to dignified, peaceful deaths. Relying on clinical knowledge and experience, and sometimes in concert with like-minded nursing colleagues and physicians, the nurses understood the very negative prognoses of these patients and the seeming futility of their prolonged process of dying. In this way, the nurses’ ethical actions were constrained by the social context that dictated specific decision-making rights.

There has been increasing attention to the “bad deaths” experienced by many patients in hospital; these deaths involve unnecessary pain and suffering, violations of the patients’ and/or families’ wishes, and violations of social values regarding decency (Bosek, Lowry, Lindeman, Burck, & Gwyther, 2003; Boyle, Miller, & Forbes-Thompson, 2005; Institute of Medicine, 1998; Steinhauser et al., 2000). Forced to participate in what the nurses believed were bad deaths for the patients they cared for, these nurses saw their values and beliefs about the patients’ rights and interests ignored and discounted by not only family members but also by physician colleagues and, at times, by the very institutions in which they were employed. Some nurses used advocacy strategies to bring the patients’ best interests forward.

Other studies have identified other barriers to nurse advocacy in end-of-life situations, including physicians, patients’ families, and lack of employer support (Thacker, 2008), as well as a lack of communication and conflicting nurse-physician views (Silén, Tang, Wadensten, & Ahlstrom, 2008). The nurses judged that challenging this array of powerful forces would be futile. Therefore, such ethical problems remained unresolved, with nurses describing the moral distress they experienced. Working in a social context where such violations of patients’ interests and dignity occurred, 1 nurse
described herself as feeling “dirty,” literally contaminated by others’ violations of the patients. This statement provided evidence of this moral residue attached to such nursing experiences.

These nurses sought to engage in relationships with families, support them by providing information and advice, and influence them toward the patients’ best interests. The nurses experienced considerable ethical concern when patients’ families violated the patients’ wishes or best interests, sometimes using power of attorney to pressure physicians. In such instances, the nurses were constrained by the social context in which they found little space open for ethical intervention and at times suffered moral distress as a result (Åström et al., 1995; Redman & Fry, 2000).

Nurses and Coworkers

Coworkers constituted a major source of relational support and assistance to the participants as they used relational space to deliberate on ethical problems and analyze the circumstances in which they worked to resolve them. A number of the nurses also described themselves as valuing avoidance of harm to other health care providers as well as patients and families in their relationships, yet a number of these nurses observed coworkers’ lapses in care, causing the nurses to look closely at possible harm to patients (Schroeter, 1999; van der Arend & van den Hurk, 1999). Several participants worried about the possible harm to interpersonal relationships that would accrue if they were to confront colleagues about lapses in nursing care. Some made explicit reference to the negative responses that they would expect if they were to criticize colleagues about inadequate nursing care. Both the nurses’ reliance on one another in their ethical deliberations and their awareness of other nurses’ actions as the source of some ethical
problems pointed to the social complexity of these nurses’ ethical deliberations. Other researchers have reported coworkers as a barrier to ethical problem solving (Varcoe et al., 2004).

Negative aspects of nurses’ coworker interactions have received growing attention in recent years. Other researchers have depicted an environment replete with tension and conflict (Cox, 2001; Duddle & Boughton, 2008; Farrell, 1999; Randle, 2003), implicating managerial inaction (Farrell, 1997) and social learning (Lewis, 2006) as perpetuating factors. Although researchers have identified newly graduated nurses as the most frequent targets of coworker bullying (B. Kelly, 1996; McKenna et al., 2003), they also have viewed a climate of horizontal violence, incivility, or bullying as affecting all parties involved. Studies have shown that although occasions of aggression by physicians, patients, and patients’ families outnumber those arising from coworker relationships, the latter can result in far greater distress (Farrell, 1997, 1999). Recent research into intraprofessional relationships in nursing has shown that experienced nurses may have developed intuitive approaches to assessing the potential for conflict in the clinical area and may subconsciously use such knowledge to alter their interactions with others, thereby recognizing the potential for and avoiding confrontations that would otherwise trigger conflict (Duddle & Boughton, 2007).

One of the participants described the experience of having reported to supervisors other nurses’ serious lapses, permanently and seriously harming her relationships with coworkers. Numerous participants indicated that they would proceed with caution in any instance involving a patient they were not caring for because the nurse caring for the patient might possess key information that the participant might not have and which
could lead to an erroneous assumption. It might be that this wish to avoid harm to colleagues is consistent with a value of preventing harm to patients and others. However, it also may have been possible that the participants sought to avoid conflict by invoking this ethic of non-interference, subsequently avoiding risk to their interpersonal relationships with particular coworkers. Anticipating interpersonal conflicts that could result from confrontations might have caused the nurses to avoid drawing attention to others’ nursing care lapses, reducing the social risks to themselves but leaving patterns of error unchecked.

How Organization Matters

Over the years, researchers have pointed out that nurses’ obligations to their employers may conflict with their obligations to their patients (Smith & Davis, 1980; Storch et al., 2004). The nursing literature also has drawn attention to the role of the employer in disempowering nurses and preventing them from fulfilling professional obligations (Chambliss, 1996; Peter, Macfarlane, et al., 2004; Varcoe & Rodney, 2002). Two nurses in this study expressed concern about the care that patients received, staffing levels, or the employment of non-RN care providers. In discussing ways to resolve problems related to inadequate resources, several participants expressed the concern that confrontational behaviour could be risky to the nurses. Other researchers also have reported this nursing concern (Varcoe et al., 2004).

In this study, the nurses sought to resolve ethical problems in their care of patients within bureaucratic, hierarchical organizations. Ethical problems arising from the behaviour or decisions of physicians or family members occurred within those organizational contexts; of the patients, family members, physicians, and nurses, only the
nurses were actual employees of the organizations. Each hospital had granted admission and other privileges to physicians, patients were recipients of care, and family members attended as visitors and sometimes substitute decision makers. Nurses, as employees of the hospital, had clear obligations to patients by virtue of nurse licensure and standards of nursing practice, but they also bore extensive obligations to the employer to complete specific work to a certain standard, participate in a cooperative and nondisruptive manner whenever possible, and provide assistance and support to others. The employers’ obligations to the nurses included remuneration and other benefits of employment and provision of resources to assist the nurses in providing care.

Along with mutual obligations, the nurses and hospitals shared an organizational culture that developed and maintained certain interpersonal norms over time. These norms included the deference mentioned earlier of the nurses to physicians, which is supported in numerous explicit and implicit ways by organizations and their cultures. Many aspects of this culture are historical artefacts based upon the male-female norms of gendered work, in which the expectation was that male physicians would make decisions and female nurses would follow such decisions. In addition, the apprenticeship education in hospital diploma schools of nursing prior to the mid-1970s promoted in nurses ideas of loyalty to hospital and physicians. The practice of holding women responsible for male-female relationships while tolerating poor behaviour from men, an aspect of the broader society, is evident in the hospital culture. These organizational norms constitute a social context that can create barriers to bringing about better working relationships between nurses and physicians in hospitals, and they can and impede nurses in bringing forward and resolving ethical problems for the benefit of patients.
There has been significant research evidence that the relationship climate in the hospital environment is currently quite tense and conflict laden between nurses and physicians and among nurses. Accounts of bullying of nurses by physicians as well as other nurses has been evident in the research literature. All of these relational stresses and strains contribute to the context in which nurses seek to resolve ethical problems. At the same time, hospitals have begun instituting zero tolerance and other policies that lay out behavioural expectations for all employees and physicians, thus providing a resort for those experiencing such behaviours. Furthermore, Ontario and other jurisdictions are developing interprofessional education and care programs in seeking to improve the professional relationships and communication among members of various health care professions.

The role of the patient has changed over the past several decades to one that includes decision making and choice in hospital care: Expectations around informed consent have ensured that. In addition, the legal precision around patient and family decision-making roles has received considerable attention in recent years, resulting in much greater awareness of and attention to this area. Nurses work to support patients and families by providing information and support related to decisions within an organizational context and culture; nurses’ knowledge of and experience with those norms and that culture can provide information on role expectations as well as latitude for action, reducing ambiguity about the possible outcomes of particular actions.

The nurses in this study experienced some ethical problems related to decisions that seemed to be organizational in nature. One participant recounted an example in which a patient suffered an untoward event seemingly because a non-RN care provider
assigned to care for him had failed to assess his situation. Following the patient’s cardiac arrest, a participant in this study experienced an ethical problem because she believed that the patient’s caregiver did not possess the knowledge necessary to anticipate the eventual outcome of the patient’s symptoms. The nurse’s ethical problem had to do with whether the hospital could have prevented the patient’s death. Participant 3 commented, “And so then after the patient dies, I am troubled . . . . That guy shouldn’t have died in my opinion.” Reflecting on her decision not to act, the participant described how she had criticized the hospital’s staff mix policy and had advocated to her nurse manager that only RNs be responsible for patients’ care, but with no response.

The nurse confronted the individual who had cared for the patient. Participant 3 recounted, “I said to her [the non-RN care provider], ‘There was probably a chance that that guy could’ve probably – cardiac condition or not – maybe lived for another 5 years.’ ” This action failed to resolve the issue. Subsequently, the participant discussed the event with another nurse, reminding the coworker that the nursing staff had worried that assigning a non-RN care provider to patients could compromise their care. Having decided to speak with the other nursing care provider, Participant 3 found herself still troubled by a death that she believed may have been prevented had a better qualified nursing care provider been assigned to him. Her decision not to act further was the result of an analysis of possible risks and benefits of action:

I said, “I think this is grounds for an incident report. . . . We all said people are going to die, and who knows how many others might have, that nobody’s picked up on and that have slipped by, but this is a perfect example of exactly what we’re talking about,” so I said, “I thought about talking to ________ [nurse manager] about it.”
However, rather than completing an incident report, Participant 3 decided on the advice of her colleague not to document the incident. She recalled what her coworker had said:

It’s not going to make a difference . . . . you know what’s going to happen? Nothing, you’re just going to make the [non-RN care provider] look bad. She’s going to come to work next week, and maybe she won’t like you so much.

Suggesting that the non-RN caregiver would resent the documentation of the incident and that the proposed action would impair the working relationship between that individual and Participant 3, the coworker recommended against action. Participant 3 reluctantly agreed: “I said, ‘Yeah, you know what? Unfortunately, you’re right, but it doesn’t sit right with me.’” Participant 3, faced with what she saw as a direct negative result of the hospital’s staff mix, decided not to act. Her previous experience informed this decision, and she determined that her efforts would not change the staff mix but would only result in negative feelings between herself and the other nursing care provider and that she could be marginalized by important others within the organization.

This individual nurse, wishing to alter a hospital policy for the patient’s safety, believed that the powerful forces ranged against her were insurmountable. Although Participant 3 had accepted significant risk as she had acted in response to other ethical problems, the social context of this ethical concern seemed to preclude effective action on her part. This example echoed the findings of Varcoe et al. (2004) that nurses’ ethical identities are contextual, dialogical, narrative, and relational.

The restructuring of Ontario’s hospitals in the late 1990s and early part of the new century resulted in organizational problems associated with the merging of specialized units. Participant 6 recounted a problem that occurred when a unit manager behaved
unfairly toward newcomer staff to her unit in a specialty new to the manager. The manager’s behaviour was so strange that it divided staff, threatened to endanger patients, and resulted in one nurse discussing the problem with the chief of the medical specialty associated with the newcomer group on the unit to ensure appropriate standards of specialty nursing care. Participant 6 recounted that eventually, the clinical specialty was situated at her current hospital instead of at the hospital where the situation had occurred.

Nursing staff cuts and increasing patient acuity had the result that nursing staffing levels constituted a serious problem, according to some nurses. Participant 10 saw this organizational issue as an ethical problem because as a senior nurse, she wished to advocate on behalf of junior colleagues unable to cope with their patient loads while also presenting herself as a successful and positive employee. To that nurse, encouraging junior staff to complete documents related to insufficiency of staffing levels was an important activity to ensure that patients received sufficient care. However, the participant went on to describe the ethical problem in such situations, a dilemma of whether to advocate for increased staffing, risking accusations of disorganized care versus saying nothing and risking harm to patients and nurses. Within this social context, support by senior nurses such as herself was one way in which newer nurses could be encouraged to fulfill their responsibilities of such advocacy.

In this type of situation, Participant 10 articulated how difficult it could be for some nurses to advocate for higher staffing levels; at the same time, she underlined the importance of doing so to ensure the safe care for patients. Participant 10 discussed the need to balance obligations and loyalties that sometimes competed. These obligations and loyalties were to patients, to themselves as nurses, and to the organizations. As
Participant 10 said, “And if you’re standing up for yourself and for your patient, you may not be standing up for your organization – that you’re telling them that there’s not enough staff.” Participant 10 identified the dilemma of whether or not to speak out, noting that “your job is at stake, and maybe somebody’s life is at stake . . . . it’s a real Catch-22, I think, because then you have your performance appraisal coming up with your manager.”

For the nurses in this study, determining when or whether to speak out about staffing levels included consideration of impacts on relationships with junior colleagues reluctant to criticize staffing levels and relationships with the hospital administration, which might not appreciate such criticism, even by senior nurses. In previous studies, the adequacy of resources for patient care has constituted a source of concern (Peter, Macfarlane, et al., 2004; Redman & Fry, 2000; Rodney & Varcoe, 2001). In the current study, the nurses identified those concerns in relation to the adequacy of nursing care provider preparation and in terms of the adequacy of staffing levels for safe nursing care.

The hospital environment provides a social organizational context in which nurses attempt to resolve ethical issues against a backdrop of power differences and tension between nurses and physicians, greater emphasis on patients’ and families’ legal rights, expectations around nurses’ obligations as employees as well as professionals, evidence of coworker friction, and gradual changes in policies and practices limiting disruptive behaviour. Developing and maintaining relationships with patients and families, brief though they may be have been, was important to the nurses in this study; at the same time, relationships with coworkers, physicians, and other care providers also were valued. Among these various complex relationships, the nurses viewed the relationships with patients as their greatest concern. Developing and maintaining relationships with other
care providers was another area of concern, and the nurses found that nursing experience and knowledge of the organization and the people within it contributed to the development of relationships. The nurses’ assessments of their relationships with others, including physicians, patients’ family members, and coworkers, helped them in their consideration of the possibilities for ethical problem resolution.

The participants who discussed ethical problems associated with organizational structures or practices described a variety of concerns, all of which they articulated in terms of threats to patient safety and/or appropriate levels of nursing care. These participants described quite varied approaches to resolving different ethical concerns, but all expressed concern about how others within the organization would view their advocacy and the impact of such advocacy on their relationships with others who could withhold support from the nurses.

Situational Analysis of Context and Relationships

Once they recognized ethical problems related to patients’ care, the nurses in this study considered whether and how to act. The foregoing discussion contained examples of the nurses engaging with others within a social context of multiple, layered, and ever-changing relationships with patients, families, colleagues, nurse managers, physicians, and other health care providers within a complex organization. The nurses described contextual details, including the quality of relationships, aspects of space and time, as well as previous experiences that informed the nurses. They gave examples of ethical problems in which they advocated with physicians or family members on behalf of patients, discussed possible solutions, and negotiated with and confronted others. Nurses who were able to resolve ethical problems often expressed pride and sometimes
exhilaration following their success. In other circumstances, the same nurses’ contextual analysis caused them to conclude that ethical action was impossible, mutually respectful relational engagement would not occur, the forces arrayed against the nurses’ preferred resolutions for patients were too great, and the only logical approach was to do nothing. In still other circumstances, the nurses acted initially, but when those actions failed to resolve the problems, they decided not to intervene further. This identified the contexts in which the nurses’ ethical problem solving was socially situated.

The nurses gave numerous examples of their unease, reluctance, and fear of the possible negative ramifications that could result from their intervening in ethical problems. Some of the unease and reluctance seemed to arise from the ambiguity around the point at which powerful others would act against the nurses. Some nurses described themselves as being worried about possibly losing the regard and support of powerful members of the health care team within the nursing unit, suggesting that physicians and nurse managers were among those powerful individuals. Within this complex, ambiguous social context, the nurses sometimes also lacked time and privacy for ethical action, further complicating the situations. Varcoe et al. (2004) also found nurses’ ethical problem solving to be highly contextual.

The nurses’ ethical problems surrounding coworkers’ care lapses, similar to the problems arising from organization, physician, and family decisions, were sometimes resolved through the participants’ interventions, although the same participants at other times either decided not to act or acted initially, but did not follow up. Although several researchers have described the hospital context as severely constraining nurses’ ethical agency by variables of physician power and organizational structural barriers, the
coworker relationship would seem to be characterized in general by much greater 
individual agency. The literature on incivility, bullying, or horizontal violence in nursing 
has suggested a learned culture of intraprofessional aggression, which may help to 
explain why, in such a social context, nurses’ situational analysis of colleagues’ unethical 
care reveals such reluctance to confront colleagues about care lapses.

Summary of the Findings

In this study, the nurses engaged with an array of others as they sought to resolve 
difficult ethical problems in the care of patients on their nursing units. Concerned first for 
patients, these nurses also described themselves as wishing to avoid harming others, 
including other care providers. Working as employees of large, complex organizations, 
these nurses generally viewed the organizations from within the lens of their own nursing 
units, but at times, they saw the organizational power hierarchy weighing in on patient 
situations, for example, those with a possibility of lawsuit. Using a background of 
professional experience and nursing knowledge, these nurses analyzed the immediate 
social context of the situation as they engaged with a range of other people to open 
relational space in order to resolve ethical problems related to their first concern, the 
patients.

Working within sometimes problematic and tense relationships with physicians, 
the nurses sometimes felt disrespected; they reported using behaviours that ranged from 
confident negotiation and confrontation to fearful subservience and silence. Sometimes, 
they suffered moral distress following their own inactions. The decisions of family 
members in relation to patients’ care, particularly those involving patients’ dying 
processes in which physicians supported the family members, often caused frustration for
the nurses, who attempted to influence decisions in favour of the patients’ best interests, cognizant of the fine line they walked. Intervening in coworkers’ ethical lapses also proved a challenge for the participants, with the same continuum of confrontation, to negotiation, to silence. The results of the nurses’ contextual analyses were socially mediated. These results also were instructive at times, providing experience that the nurses could later use in resolving future ethical problems.

Conclusion

This study revealed that the study nurses’ values included discerning and acting in accordance with the rights and wishes of their patients and protecting the patients from violations of those rights. They engaged in relationships with patients and others in order to act to bring about the best outcomes for patients. As part of the nurses’ relational engagement, they were concerned with avoiding harming others in the course of their practice and as they resolved ethical problems. The characteristics of these nurses that supported ethical problem solving included professional and clinical knowledge and experience, which gave the nurses confidence in their ethical decisions. These nurses encountered a wide range of ethical problems related to patients’ care, including violations of the patients’ wishes or best interests by physicians, families, or coworkers, in a range of patient circumstances, including end of life. The nurses attempted to engage in relational interaction with others, including patients, family members, the nurse manager, coworkers, and other care providers such as physicians visiting the nursing unit, and they saw such interaction as a support to ethical problem solving. Barriers to ethical problem solving included poor interpersonal relationships, characterized by disrespect and disengagement on the part of physicians and coworkers; litigiousness on the part of
family members; and a hospital structure that was extremely hierarchical and distributed power such that the nurses often felt disempowered in relation to physicians, administrators, and others.

The nurses’ actions included a range of approaches that were socially mediated, namely, those that were very active, involving confrontation and disregarding orders; less confrontational approaches such as discussion, suggestion; and reminders; and those that could be characterized as doing nothing. In deciding to act, the nurses considered respect for the wishes and/or best interests of patients, the identities of the other persons involved, hospital policies, and resources. This researcher believes that within the complex layers of relationships on the nursing unit, the nurses’ attempts to maintain good relationships with others were socially situated because those nurses worked within those relationships to bring about the best outcomes for the patients. Risk of acting and of not acting constituted an aspect of the social context that contributed to the nurses’ decision of whether and how to act.

Many of these findings are consistent with previous studies. However, in this study, ethically active nurse described their decisions to act or not to act in relation to ethical problems. The nurses often described their decisions as being the result weighing specific risks; this finding not been well documented in previous studies. Likewise, this research revealed the role of coworkers as the source of ethical problems for nurses as well as participants in ethical deliberation.

The social context of multiple relationships between the nurse and others influenced the nurses’ ethical decision making in a number of ways. The nurses viewed positive and trusting relationships as providing support, information, reflective
discussion, and consideration of possible alternative actions. The nurses found engaging in these relationships within this relational space to be important because it allowed them and others to consider the various risks and benefits in particular actions. The nurses reported that relationships characterized by tension or poor communication created barriers to ethical problem solving; a failure to engage in relationship resulted in the absence of relational space in which to work together to resolve ethical problems. The organizational context sometimes reduced the nurses’ ethical activist behaviours, especially if the possible outcomes of various actions were obscure or ambiguous, or if poor relationships with powerful others such as physicians were tolerated. In this way, these nurses’ ethical activities were deeply contextual and socially situated, involving their situational assessments of the individuals involved, the risks to patients, as well as nurses’ knowledge of the organizations. It was noteworthy that the nurses in one hospital spoke of organizational policies that supported clear roles and civil communication, thereby supporting functional relationships.

The nurses in this study, when considering possible ethical interventions within a social complex of interdependent relationships, seemed to assess the risks of various alternatives: risks to the patients of inaction, risk to others of action or inaction, and risks to themselves of particular actions. Within this risk assessment, all of the nurses emphasized physicians’ power: Physicians’ disrespectful communication and actions constituted a significant barrier to ethical problem solving for most of these nurses. These nurses discussed the power conferred on patients’ family members through legal power of attorney. The nurses also described the relational power of coworkers in the nurses’ mutually dependent relationships; seeking to maintain mutually respectful relationships
in the health care team with coworkers, the nurses exercised extreme caution in their approach to coworkers’ care lapses. The nurses seemed to carry out a situational analysis within a particular social context as they considered the likely outcomes of various actions, considering whether the risk made action worthwhile. Within this group of nurses, knowledge and experience were key personal qualities in identifying, considering, and acting on specific ethical problems, suggesting that knowledge of self, others, and the organization all aided the nurses in anticipating the likely outcomes of various actions.

Nurses have found that the organization itself could contribute to their ethical problems by privileging the decisions and actions of some care providers such as physicians and devaluing the authority of others, such as nurses. In this study, the organization provided an important social context within which the nurses considered each of the ethical problems. In particular, the nurses were less likely to resolve ethical problems that involved physicians, families, and administrators. In those instances, the nurses were much more likely to abandon attempts to resolve the problems, but in doing so, they experienced moral distress at not having been able to protect or assist the patients.

Although relational ethics did not form the original conceptual framework for this study, the major themes of that emerging theory contributed significantly to an understanding of the aspects of the interpersonal context of nurses’ ethical decision making. Deeply concerned for their patients’ welfare, the ethically active nurses in this study engaged with those patients to discern their wishes, needs, and best interests. They worked with others in a social context of complex relationships, including variations on ethically supportive relationships in which they engaged in opening relational space and
working together to resolve not only ethical problems but also relationships characterized by such aspects as poor respect, disengagement, and the absence of relational space. The relational themes provided areas of focus for improving the circumstances that nurses experience as they work to bring about the best outcomes for their patients.
CHAPTER 8: CONCLUSION

This chapter includes a brief summary of the study, a discussion of the study findings, and exploration of implications for theory, further research, and practice. The following discussion focuses on each of these areas.

Brief Summary of the Study

Recent decades have seen a growing concern on the part of nurses regarding the organizational environment in which they seek to resolve ethical problems related to patient care. Although nurses have been shown to be “for their patients,” their success in resolving ethical problems has not matched this commitment. The hierarchical, bureaucratic nature of the hospital environment, coupled with power differentials between staff nurses and others such as physicians, has been seen as combining to reduce the moral agency of nurses. Previous researchers have focused on ways in which either nurses’ personal qualities or characteristics of the employing organization support and interfere with nurses’ ethical problem solving. However, many questions remain about the interactions of these variables. This study sought to elucidate the extent to which nurses perceived their personal qualities, as well as organizational characteristics, to influence their ethical decision making.

The conceptual framework for this qualitative investigation provided a relational ethics lens within which nurses’ ethical problem solving occurred within a complex of relationships with others, including patients, patients’ families, physicians, coworkers, and others. The nurses saw the patients as their greatest concern, and they engaged with the patients to discern their wishes, needs, and best interests. A complex of other relationships constituted supports for or barriers to ethical problem solving and thus
contributed to ethical problems and/or resolution of those problems. The nurses worked within a social context of multiple layered and complex relationships within a hierarchical, bureaucratic organization with the desire to bring about the best outcomes for patients. At the same time, the nurses often sought to develop, maintain, and protect mutually respectful relationships with others. Within this relational social context, the nurses assessed the risks and benefits of various alternatives for patients, themselves, and others. The nurses seemed to carry out a contextual assessment, analyzing the presence of mutual respect, the extent of relational engagement, and the potential for opening relational space in order to work with others to resolve ethical problems for patients’ best outcomes. The nurses’ ethical actions were socially situated within this complex interpersonal context.

The participants included 10 experienced registered nurses who identified themselves as ethically active. They worked in two different hospitals in Ontario, a medium-sized community hospital in a smaller city and a large teaching hospital in a large metropolitan area. The nurses participated in one audiotaped interview each, responding to specific trigger questions about their experiences with ethical problems that they were able to resolve and with ethical problems that remained unresolved. Data analysis used the constant comparison approach and identified key themes, including concern for patients, nursing experience, layered relationships, the nurse and the organization, and situational analysis of context and relationships. Subthemes included the nurses’ relationships with physicians, the nurses and decisions made by patients’ families and physicians, and the nurses’ relationships with coworkers.
What was revealed in this study was a description of nurses who all spoke of the patients as being their primary concern, whose professional experience provided a key asset in resolving ethical problems, and who described an array of ethical problems originating with specific others’ decisions or actions within a social context of multiple layered relationships. The participants’ primary experience of the organization was within their work on the nursing units; however, several nurses believed that the higher administration became involved in ethically problematic situations in ways that this investigator saw as having as their focus the legal protection of the organization. Nurses in both organizations represented in this study described numerous difficulties in their relationships with some physicians, many of which seemed to involve the power differential between physicians and nurses within the organization.

Some ethical problems the nurses experienced originated with physician actions or decisions; nurses saw those and other physician behaviours as constituting a direct and negative impact on the nurses’ ethical problem solving. The patients’ family members, perceived as needing support, explanations, and information from the nurses, were the origin of ethical problems for a number of participants, particularly in end-of-life situations. Family and physician decisions caused a number of these nurses to experience moral distress as their patients experienced a “bad death” involving unnecessary suffering and/or indignity. Ethical problems also arose for these nurses because of coworkers’ behaviours, such as theft of narcotics and other supplies, as well as lapses in integrity, veracity, and civility to patients. The nurses viewed resolution of ethical problems arising from coworkers’ decisions or behaviours as challenging because ethical action risked
jeopardizing the coworkers’ well-being, the nurses’ relationships with coworkers, and possibly the nurses’ reputations and image.

Notwithstanding these issues, a number of nurses in this study did act on their ethical decisions when they believed the risk to patients to be high. Those active ethical problem solvers, however, also were very reluctant to act when they perceived the risk to patients to be low but the risk to the well-being of themselves or other care providers to be high. The nurses seemed to engage in a situational analysis within a socially mediated context in which they considered the risks and benefits of various alternatives. This finding reveals that the nurses not only worked within a layered relational context in their patient care but also considered the impact of ethical decisions within that relational context. In this way, the nurses’ ethical actions were deeply socially situated.

Significance

This study contributed results shared with other investigations as well as findings that the nursing literature has not previously documented. For example, nurses in this study addressed an extensive list of ethical problems; other researchers also have identified many of the ethical problems with which the nurses in this study concerned themselves (Ahern & McDonald, 2002; Fry et al., 2002; van der Arend & van den Hurk, 1999). Likewise, the nurses in this study identified their patients as their primary focus of concern. Others have also reported this finding (Erlen & Sereika, 1997; Fry et al., 2002; Lützen & Schreiber, 1998; Redman & Fry, 2000; Wurzbach, 1999). A key finding of this study is that all of the nurses identified professional experience as an important quality supporting their ethical activism; other investigators also have found this (B. Kelly, 1998; Rubin, 1996); however, this is not a uniform finding, and earlier studies have provided
conflicting results. The impact of the power differential between nurses and physicians and of physicians’ behaviours on nurses’ moral agency has been documented extensively (Åström et al., 1995; Enes & de Vries, 2004; Erlen & Sereika, 1997; Hutchinson, 1990; Lützen & Schreiber, 1998; Raines, 2000; Redman & Fry, 2000; Schroeter, 1999; Sleutel, 2000; Sundin-Huard & Fahy, 1999; Woods, 1999). The current study also provided ample evidence of these findings. In recent years, the impact of the organization on nurses’ moral agency has received increasing attention, and reports of this phenomenon documented in the nursing research literature (Chambliss, 1996; Varcoe & Rodney, 2002; Peter, Macfarlane, et al., 2004) contributed to the impetus for the current investigation. It is not surprising that the participants in this study described ways in which the organization, as well as the relationships within it, contributed in both positive and negative ways to the approaches taken by these nurses to ethical problems. This study contributes further evidence of each of the findings and draws attention to the complex social milieu that forms the context for nurses’ ethical action.

Other investigators have not generally asked all of their study participants to discuss ethical problems that were successful in resolving as well as some that they failed to resolve. It is within the context of this dichotomy that the investigator was able to evaluate the participants’ decisions not to act to resolve ethical problems: Nurses who took significant risks to resolve some problems decided in other instances that attempted problem resolution would be futile or so risky as to call into question such actions. The methodological approach of inquiring into study participants’ successful ethical problem resolution and instances that did not result in problem resolution has not been widely reported in the literature. Many previous researchers have reported on nurses’ successful
ethical action without exploring those same nurses’ experiences of ethical inaction, or the converse. By comparing situations in which nurses acted and those in which nurses were unwilling or unable to act, this study underlined the importance of social contextual analysis, complex interpersonal relationships, and the decision-making power within those relationships.

Only a few other investigators have explored the role of patients’ families in nurses’ ethical problems (Enes & de Vries, 2004; Lorenson et al., 2003). In this study, participants described the complex social relational context within which nurses, patients, families, and physicians participated in care decisions, providing evidence of the multiple layered relationships in such circumstances and drawing attention to the extent to which nurses’ ethical actions are socially situated. The current investigation provided examples of the role of the hospital’s hierarchy, adding evidence of the layered social complexity in which the decision-making power at times marginalized patients and nurses.

Few studies have focused on ethical problems arising from the actions or decisions of nurses’ coworkers (Fry et al., 2002; Hart et al., 1998; Hutchinson, 1990; Severinsson & Kamaker, 1999; Sorlie et al., 2005). In the current investigation, there was evidence that coworkers supported but also interfered with nurses’ ethical problem solving. The interviews revealed that the nurses had to exhibit extreme caution in confronting coworkers regarding care lapses or other unethical behaviours. Within this study, the nurses’ caution was seen not only as a wish to protect other caregivers but also possibly as recognition of the risk of severe harm to coworker relationships in a social context where nurses are dependent on one another to accomplish the nursing care of their patients. The importance of mutual respect to these nurses in effective team
functioning rendered it difficult for the nurses to engage in criticism of coworkers.

Finding ways to do so without harming coworker relationships was a challenge for these nurses, and they exhibited great sensitivity and delicacy in their interactions with coworkers.

Revealed through the methodology of this study, the investigation found nurses carrying out a type of social risk analysis, focusing on risks to patients of not acting and risks to nurses and others of various possible actions, pointing to the socially contextual nature of nurses’ ethical action. Few other researchers have presented this finding in this way (Varcoe et al., 2004); it seems to constitute another important finding in this study.

This study provided support to previous findings regarding the range of ethical problems considered by nurses, the nurses’ focus on patients’ rights and/or best interests, the ethical challenges afforded nurses by virtue of the powerful role of physicians, and the impact of the organization and the relationships the nurses experienced. Previous studies have provided conflicting evidence of the role of nursing experience in the resolution of ethical problems; the results of this study provided further evidence of the necessity, but not the sufficiency, of professional experience as a precondition to the effective resolution of a wide range of ethical problems.

In addition, this study provided new evidence about the way in which nurses’ relationships with patients’ families and the role of those relationships ethical problem solving are socially situated, including nurses’ efforts to provide information and support to families as they worked through decisions and choices. The nurses’ descriptions of ethical problems arising from family members’ decisions contributes further valuable research evidence in this poorly researched area. Likewise, the role of nurses’ coworkers
as supports and barriers to ethical problem resolution, and the caution the nurses in this study exhibited in relation to resolving ethical problems arising from coworkers’ behaviour, constitute valuable additional information in yet another poorly researched area.

Finally, this study contributes important new information about the role of interpersonal risk in nurses’ ethical decisions, revealed as the nurses discussed the social context of the ethical problems that they resolved and others that they were unwilling or unable to resolve. As reported by other investigators, the nurses’ ethical problems often are not determining what should happen, but rather finding ways to bring about the results that the nurse believed would provide the best outcomes for the patients. What emerged from these descriptions is a social situational analysis, in which the nurses assessed the interpersonal risks and benefits associated with particular alternatives available within particular social contexts in resolving ethical problems.

Limitations and Delimitations

This investigation explored the perceptions, beliefs, and experiences of 10 nurses who worked at two general hospitals, one a large teaching hospital in a large metropolitan area and the other a medium-sized community hospital in a smaller city. Discussion of the limitations and delimitations of the study focuses on the criteria of confirmability, dependability, credibility, and generalizability as presented by Miles and Huberman (1994).

The study provided an opportunity for 10 nurses to describe their qualities, experiences, and relationships related to their ethical problem solving, with the result that the transcribed interviews constituted the material used to interpret their experiences. The
participants’ interview data and the process of the investigation were the sources of the conclusions drawn in this study, providing confirmability or external reliability (Miles & Huberman, 1994). Likewise, reasonable dependability of the study was reflected in the fact that one investigator carried out all interviews, completed the data analysis, and carried out colleague review at intervals during the data analysis (Merriam, 1998; Miles & Huberman, 1994). Although the study did not include any triangulation of methods, the thick descriptions provided in the account support the credibility of the conclusions, and the coherence of the results further support the credibility of the study, the link between the findings and the conceptual framework, and the identification of areas of uncertainty (Merriam, 1998; Miles & Huberman, 1994).

It is not possible to generalize the results of this study beyond this sample without extreme caution. The design of the study delimited its generalizability: Two hospitals, thus two organizational cultures, comprised the setting, and experienced hospital staff nurses, not new nurses, nurse managers, or nurses in other settings, comprised the sample. However, thick description allows the reader to evaluate possible transferability or evaluation of the conclusions for generalization to other settings (Merriam, 1998; Miles & Huberman, 1994). The credibility of the study should allow readers whose experience is similar to the study participants find these results to be transferable to their own settings. The fact that many of the findings were consistent with previously developed theory and previous research also supports the potential generalizability of the findings.
Implications for Practice and Education

The participants in this study discussed a number of problems and issues that have implications for nursing practice, the practices of other health care providers, and the practices of health care organizations. In addition, these problems focus attention on educational approaches to mitigate or solve these problems. The following discussion presents both.

Several researchers have made a number of recommendations related to the staff development education of nurses, physicians, and others. Many of those recommendations have clear implications for the prelicensure education of students in health disciplines, suggesting that education strategies directed at practicing nurses, doctors, and other health professionals also might be of benefit when integrated into prelicensure programs within postsecondary institutions. A number of these recommended strategies would deal directly with the frequent complaint of nurses that they feel marginalized, silenced, or otherwise excluded from discussions about moral problems. For example, a number of researchers have suggested strategies that could educate nurses about ethical problems and help them to become more articulate in describing ethical problems (Badger & O’Connor, 2006; Espinosa, Young, Symes, Haile, & Walsh, 2010; Malloy et al., 2009); others have suggested that both nurses and physicians receive such training (McAndrew, 2010). One group, noting nurses’ discomfort around their marginalization from disclosing physicians’ errors to patients, recommended educating nurses and others in ways to carry out this relational practice with patients and families (Shannon, Foglia, Hardy, & Gallagher, 2009). The current emphasis on interprofessional education and care, for example, that which the current
Ontario Ministry of Health and Long-Term Care has led through HealthForce Ontario, may actually contribute to improvements in communication and ethical problem resolution among nurses and physicians. What is required are changes in the communication patterns between nurses and physicians, which different approaches to both education and practice can foster, approaches that can change the power structure between the two professions.

Reports in the literature have advised nurses and nurse managers to work together not only to improve the standards of ethical practice in their nursing units but also to increase open communication around ethical concerns (Badger & O’Connor, 2006). Other researchers have reported somewhat positive results from the use of workshops in which nurses can develop greater skills in dealing with morally problematic situations (Beumer, 2008) or the use of ethics conversations facilitated by members of a hospital’s clinical ethics committee (Helft, Bledsoe, Hancock, & Wocial, 2009). However, others have warned that individual nurses’ reflection, finding new ways of working through ethical problems, and ethical interventions can accomplish only so much; it is collective action among not only staff nurses but also in concert with nurses in leadership roles that will bring the greatest change (Rodney, Doane, Storch, & Varcoe, 2006).

A number of previous investigators have recommended the institution of strategies in health care organizations to improve the participation of nurses in ethical problem solving. Recommendations have included changes in the process and structure of organizational decision making, as well as changes to the profile and authority of staff nurses. Some investigators have recommended that empowerment of nurses by their employers through diverse means also would improve nurses’ involvement in resolving
ethical problems (Corley, Minick, Elswick, & Jacobs, 2005); others have suggested that alterations in hospital policies and the creation of cultures that ensure nurse participation in conversations around such issues as end-of-life care could improve communication between nurses and physicians. Yet others have urged more specifically that the employing organizations ensure that staff nurses are involved directly and actively in the organization of the settings in which they practice (Rodney et al., 2006). Research results have suggested that such strategies as mandating multidisciplinary team meetings, ensuring nurse participation in family meetings, and introducing palliative care teams to such settings as intensive care units can reduce the moral distress experienced by nurses (Hamric & Blackhall, 2007). Others have suggested that hospitals institute multidisciplinary rounds, that they ensure nurses’ involvement, and that approaches be used to improve communication with patients’ families (Gross, 2006).

Health care organizations have a responsibility to develop specific structural approaches to improve the communication between nurses and physicians. Others have pointed out that simply encouraging greater collaboration has not borne results (Hamric & Blackhall, 2007) and will not unless specific approaches are used. Through strong organizational leadership and the development of deliberate organizational changes that place bedside nurses in positions of more equal authority, the current marginalization and silencing of nurses (often by themselves) can be reduced, and nurses’ ethical perspectives can be brought to the fore.

Implications for Theory and Research

The results of this investigation suggested that some of the most difficult types of ethical problems for nurses are related to end-of-life situations. Others have pointed out
that nurses, who spend much more time at patients’ bedsides than physicians, may be more in tune with patients’ perspectives; nurses also may experience greater moral distress because of the nurses’ greater exposure to patients’ suffering. Hamric and Blackhall (2007), who found that nurses experienced much greater moral distress and at the same time more often accurately perceived patients’ situations to be futile than did physicians, suggested that although nurses may “focus on the suffering of the many . . . physicians are more concerned with the survival of the few” (p. 427). This difference in perspective is important to explore further because it provides insight into some differences in these two professions’ perspectives, especially when the investigators also found that the physicians perceived nurse-physician collaboration to be effective, but the nurses did not. These findings support the views of others that nurses and physicians may view ethical problems from very different perspectives. Further theoretical discussion of similarities and differences between the ethical experience of nurses and others such as physicians may be useful in improving nurses’ participation in the resolution of ethical problems.

This study used a relational ethics lens to reveal aspects of the situational analysis carried out by the nurses in the study. Bergum and Dossetor (2005) described an initial study leading to the elucidation of the key themes of mutual respect, relational engagement, embodiment, and ethical environment. These concepts added conceptual support to the current investigation. There is a need for further research to elaborate each of these themes, identify ways in which they interrelate, and suggest how they might be of use in a wide range of further research.
Principle-based ethical approaches emphasize the moral principle of autonomy or self-determination, and in health care applications, they often depict ethical decision makers as autonomous, objective, and disinterested (Chambliss, 1996). The moral distress experienced by the nurses in this study, when forced to care for patients whom they believed should have been allowed to die, can be seen as arising from the lack of autonomy experienced by the nurses in the options available to resolve such ethical problems (Chambliss, 1996). Participation in violating patients’ best interests at end of life also created problems of moral residue at times for some nurses.

In the past decade, theoretical discussion has focused on limits to individual autonomy that have reflected a more realistic view within health care situations. For example, C. MacDonald (2002) pointed out that social and legal authority form the basis for the autonomy of a health profession and that both membership in a profession and employment in an organization relate to individual practitioners’ autonomy in caring for patients. That researcher suggested that conceptualizing nurse autonomy as being relational may help nurses to experience less moral distress. C. MacDonald indicated that the current thrust toward greater nurse-physician collaboration will require increased consideration of the social and organizational variables that will support increased nurse autonomy.

Building on this concept of relationship, Hardingham (2004) theorized a relational basis for moral integrity. Citing May, Hardington pointed out that critical thinking, coherent values, and an approach to action that is principle-based characterize moral integrity and that it involves reflective processes rather than a set of beliefs. Hardingham pointed out that integrity is intensely developmental. Accepting that
relationships form the context within which moral integrity occurs, Hardingham theorized that nursing ethics should work toward the goal of a strong moral community. Pauly, Varcoe, Storch, and Newton (2009) proposed revising the definition of moral distress, from Jameton’s depiction of nurses knowing the resolution of an ethical problem but being obstructed by the organization in bringing about that resolution, to an image of nurses’ moral distress as being “a function of a balance between individual and contextual constraints” (p. 570).

Within this study, some nurses were able in some circumstances to bring about interventions for the patients’ best outcomes and resolve their ethical problems; in other instances, they were unable or unwilling to act or continue to act to resolve other ethical problems; those nurses’ ethical actions or inactions were seen as being profoundly relational. This finding supports a theoretical focus on nurse autonomy as relational and on situations in which the nurses experienced moral distress as being influenced both by the nurses as individuals and by the organizational and relational context, revealing nurses’ ethical action to be deeply socially situated.

The findings of this study suggest that poor communication between nurses and physicians contributed to a number of ethical problems. Other researchers have suggested that further investigation is needed into how poor communication and poor relationships contribute to ethical problems (Bosek, 2009) and into the evaluation of specific approaches intended to improve communication (Espinosa et al., 2010). Others have suggested that future research focus on improving the ethical climate at the nursing unit level, for example, such as by using participatory action research approaches (Storch et al., 2009) and spanning the organization (Corley et al., 2005). Finally, investigators
focusing on moral distress have suggested that organizational variables contributing to moral distress be identified (Pauly et al., 2009) or that researchers focus on investigating whether nurses’ lack of language around ethical deliberations contributes to nurses being silenced in ethical problem solving (Malloy et al., 2009). All of these are important areas to investigate, and they could be seen as fruitful lines of inquiry arising out of the current investigation.

According to the participants in this study, nursing experience is an important personal variable in nurses’ ability to identify, consider, and resolve ethical problems. This area, particularly exploration of the process involved in the nurse’s development of such abilities, deserves further consideration. Further areas deserving closer examination include the role of nurses’ knowledge of the organization as well as the nurses’ assessment of other contextual variables.

The relationships among staff nurses have received very little attention by researchers to date. It became evident in the current study that these relationships are extremely important and that nurses give considerable attention to protecting those relationships. There has been very little exploration of the ways in which these relationships are developed and maintained, or their specific role in supporting nurses experiencing ethical problems. Furthermore, evidence has shown that ethical problems arising out of coworkers’ behaviours cause nurses considerable distress and that nurses proceed cautiously in intervening in such ethical problems. Research is needed not only to explore further nurses’ ethical problems that result from other nurses’ care lapses but also to determine why nurses are so reluctant to intervene in such ethical problems: Is it related to the incivility or bullying, also called horizontal violence, that is discussed so
prevalently in current nursing literature (Cox, 2001; Farrell, 1997, 1999; Randle, 2003)?

This study involved two health care organizations that were different in important ways: One was a large metropolitan teaching hospital, and the other was a smaller community hospital in a smaller city. One of the hospitals employed a clinical ethicist, and the nurses at that hospital reported nurse-physician collaboration in resolving ethical problems, but the nurses in the other hospital pointed out that the physicians rarely involved themselves in shared ethical problem solving. There is a need for further research into the impact of the clinical ethicist on the extent of nurse-physician collaboration in ethical problem solving.

Through further research and theoretical exploration, it will be possible to continue to develop knowledge of the ethical problem solving of nurses and the social context in which those nurses experience supports and barriers to problem solving. Finally, in the current study, the nurses seemed to carry out a situational analysis of the risks and benefits of particular approaches to ethical problem resolution. Further exploration of how nurses’ ethical action is socially situated is needed.

Conclusion

This investigation sought to elucidate ways in which experienced staff nurses’ qualities interacted with the hospital organizational context in relation to ethical problem solving. What was revealed was that the organization was experienced by these nurses as the multiple layered relationships that they experienced on their own nursing units. The nurses identified their patients as their main concern, and they sought to ascertain their patients’ wishes and preferences. In seeking to engage relationally with others, including patients, nurse managers, coworkers, family members, physicians, and others, these
nurses identified and considered specific ethical problems and possible actions to resolve those problems. Within this complex social context, the nurses attempted to ascertain the probable outcomes of various actions. The nurses, working within this complex array of relationships, sought to assess various risks to the patients (e.g., of not acting) and to themselves or others of acting. This complex array of relationships underlined how deeply socially situated the nurses’ ethical problem solving and ethical actions proved to be. The relational ethics concepts of mutual respect, relational engagement, embodiment, and ethical environment helped to explore the complex social context of the nurses’ ethical deliberations and actions. This study has implications for nursing education, research, practice, and theory development.
REFERENCES


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APPENDIX A: INFORMATION SHEET

OISE/UT
ONTARIO INSTITUTE FOR EDUCATION OF THE UNIVERSITY OF TORONTO
252 Bloor Street West
Toronto, Ontario
Canada M5S 1V6
Telephone: (416) 923-6641

Do you view yourself as an ethically-active Registered Nurse?

If so, please read!

Glenna Knutson, R.N., is a doctoral student in the Ontario Institute for Studies in Education at the University of Toronto. She is seeking Registered Nurses, currently employed in this organization, who have at least five years’ experience and who view themselves as ethically active nurses, to participate in a study entitled Nurses’ Ethical Decision Making: Influence of Perceived Personal and Organizational Characteristics.

Participation in this study is completely voluntary and should you wish to participate, you may decline to answer any question, and may withdraw from the study at any time. The risk to you of participating in this study is minimal, and confidentiality and anonymity will be strictly protected at all times. While you may not benefit from the study, the knowledge they offer through your participation may enhance future nursing education and patient care.

If you are interested in participating, please contact Glenna Knutson by one of the methods below, and she will send you an information package about her doctoral research study focusing on nurses’ experience of ethical issues.

Those who have received and read the information package and decide to participate will be asked to sign and return the consent form included in the information package, agreeing to participate in a 1.5 hour confidential interview by phone or in person early in 2006.
This study will be conducted by Glenna Knutson under the supervision of Dr. Nina Bascia, Theory & Policy Studies in Education, OISE/UT, 252 Bloor St. West, Toronto, Ontario Canada, M5S1V6, phone (416) 923-6641, ext. 2511, fax (416) 926-4741, email: nbascia@oise.utoronto.

If you are interested in receiving further information about this study, please contact Glenna Knutson at 807-xxx-xxx (home) or xxx-xxx (work), or via email: xxx@xxx
APPENDIX B: EXPLANATION OF THE STUDY

Dear Registered Nurse:

I am a doctoral student at the Ontario Institute for Studies in Education in the University of Toronto, and I invite you to participate in a research study entitled Nurses’ Ethical Decision Making: Influence of Perceived Personal and Organizational Characteristics. I am also an Associate Professor and Post-RN Program Coordinator at Lakehead University School of Nursing. This research study seeks to interview ten Registered Nurses, to gain information about ethically-active Registered Nurses’ perceptions of the influence of their own personal characteristics and the characteristics of their employing organization on how they perceive, make decisions around, and act in relation to ethical problems they encounter in their work.

I understand that you are an employed Registered Nurse, that you have at least five years’ full-time equivalent clinical nursing experience, that you identify yourself as ethically active, and that you responded to information about this research study which was provided in your nursing employment setting. By the term ethically active, I mean a nurse who deals with ethical issues in the course of caring for patients, for example by advocating, problem solving, etc.

Your participation in this study would involve participating in an audiotaped telephone or face-to-face interview of approximately one and one half hours’ duration, early in 2006. It is anticipated that you will not incur any costs in relation to your participation in the research study, nor is any financial compensation offered for your participation. Your participation would involve answering questions about the influence of your personal characteristics and the organization’s characteristics on how you recognized, worked through, and acted in relation to ethical problems you have experienced in your clinical practice.

Your participation in this study is completely voluntary, and you have the right to decline to answer any specific question, or to withdraw from the study at any time, without any penalty or loss of benefits to which you are otherwise entitled. The risks to you of
participating in the study are minimal. You will be informed in a timely manner if information becomes available that may be relevant to your willingness to continue to participate in the study. While you may not personally benefit from participation in the study, your participation may ultimately help to improve future nursing education and patient care. Should you request it, a summary of the results of the research will be forwarded to you after completion of the study.

In order to protect your privacy and to keep your information confidential, following the audiotaped interview you will subsequently be assigned a code to be used during audiotape transcription and data analysis. The coding scheme linking your identity with your transcript will be maintained under lock and key at a location distinct from the location where the interview transcripts are stored. The code will be destroyed within one year of the completion of this study. Only I and my supervisor will have access to the interview transcripts, only I will have access to any information that may identify you, and I and my supervisor will both ensure that extreme caution is maintained to ensure the privacy and anonymity of participants in this study. However, there is one exception to this assurance of anonymity: you should be aware that I, as a member of a regulated health discipline, would be compelled by law to report any case of sexual abuse by a member of any regulated health professions, revealed to me by a participant in this study. Your consent form and the transcript of your interview will be maintained in a double-locked container for seven years. All identifying information will be removed from your interview transcript prior to data analysis. I will ensure that no data maintenance documents and worksheets, used during data analysis, contain any information that could identify you. Your identity will remain anonymous and confidential in any report that I prepare for publication or public presentation, and your employing institution will not be named in any report.

The study will be conducted under the supervision of Dr. Nina Bascia, Theory & Policy Studies in Education, OISE/UT, 252 Bloor St. West, Toronto, Ontario Canada, M5S1V6, phone (416) 923-6641, ext. 2511, fax (416) 926-4741, email: nbascia@oise.utoronto. Should you have any questions or concerns, you can contact me at 807-343-8248 (office) or 807-345-7115 (home).

Glenna Knutson, Reg.N., MScN, EdD (Cand.)
APPENDIX C: INFORMED CONSENT FORM

Informed Consent Form

I have read an information letter about the study entitled Nurses’ Ethical Decision Making: Influence of Perceived Personal and Organizational Characteristics, a doctoral research study being carried out by Glenna Knutson, a doctoral student at the Ontario Institute for Studies in Education at the University of Toronto. I understand that the research study seeks to interview ten participants, to gain information about ethically-active Registered Nurses’ perceptions of the influence of their own personal characteristics and the characteristics of their employing organization on how they perceive, make decisions around, and act in relation to ethical problems they encounter in their work.

I am an employed Registered Nurse, with at least five years’ full-time equivalent clinical nursing experience, and I identify myself as ethically active. I understand that my participation in this study will involve participating in an audiotaped telephone or face-to-face interview of approximately one and one half hours’ duration, early in 2006, in which I will be asked to answer questions about personal and organizational influences on my ethical decision making processes. I understand that I will not incur any costs in relation to my participation in the research study, and that no financial compensation offered for my participation.

I understand that my participation in this study is completely voluntary, and I have the right to decline to answer any specific question, or to withdraw from the study at any time, without any penalty or loss of benefits to which I am otherwise entitled. I understand that the risks to me of participating in the study are minimal. I understand that I will be informed in a timely manner if information becomes available that may be relevant to my willingness to continue to participate in the study. I understand that, while I may not personally benefit from participation in the study, my participation may ultimately help to improve future nursing education and patient care. I understand that, should I request one, a summary of the research findings will be provided to me.
I understand that my identity will be kept confidential throughout the study, that I will be assigned a code prior to interview transcription, and that any identifying information will be removed from the interview transcript prior to data analysis. I understand that my interview transcript will be maintained under double lock for seven years, after which time they will be destroyed. I understand that the coding scheme linking my identity with my transcript will be maintained under lock and key at a location distinct from the location where the interview transcripts are stored, and that the code will be destroyed within one year of the completion of this study. Only Glenna Knutson and her supervisor will have access to the interview transcripts, only Glenna Knutson will have access to any information that may identify me, and both Glenna Knutson and her supervisor will both ensure that extreme caution is maintained to ensure my privacy and anonymity in this study. I understand that there is one exception to this assurance of anonymity: should I reveal to Glenna Knutson any case of sexual abuse by a member of any regulated health profession, as a member of a regulated health discipline she would be compelled by law to report such a case to the appropriate regulatory body.

Only Glenna Knutson will have access to the consent form or any other information that identifies me. Only Glenna Knutson and one transcriber will have access to the audiotape of my interview, and to the transcript of that interview. I understand that Glenna Knutson intends to publish the results of this study, and that my identity as well as my employing institution’s identity will remain anonymous and confidential in any report for publication or public presentation. I understand that Glenna Knutson’s study will be conducted under the supervision of Dr. Nina Bascia, Theory & Policy Studies in Education, OISE/UT, 252 Bloor St. West, Toronto, Ontario Canada, M5S1V6, phone (416) 923-6641, ext. 2511, fax (416) 926-4741, email: nbascia@oise.utoronto. I understand that, should I have any questions or concerns, I can contact Glenna Knutson at 807-343-8248 (office) or 807-345-7115 (home).

I agree to participate in the doctoral research study, Nurses’ ethical decision-making processes: influence of personal and organizational characteristics, and I agree to have Glenna Knutson contact me at the telephone number below.

By signing below, I am indicating that I am willing to participate in the study, I have received a copy of this letter, and I am fully aware of the conditions above.

Name: ________________________________

Signed: ________________________________

Date: ________________________________
Contact Telephone Number: __________________

Please initial if you would like a summary of the findings of the study upon completion: _____

Please initial if you agree to have your interview audiotaped: _____
APPENDIX D: DETAILED INTERVIEW PROTOCOL

As we begin, I’d like to ask a few demographic questions:

What is your age? Age ___ Sex ___
How many years have you nursed altogether? ___
How many years have you practiced in your current position? ___

In this research study, I’m interested in the ethical problems nurses encounter in their clinical practice, how they think about those problems, and how they resolve them. In this interview, I’d like to focus on some of the main types of ethical problems you encounter. For each main type of problem you describe, I’ll have a series of questions to ask or areas in which to invite your comment. Your nurse manager described a specific example, in nominating you for inclusion as a participant in this study. Could we begin with that problem? (Describe to participant situation nurse manager described) If not, could you describe another type of situation that is ethically problematic for you?

What situations present ethical problems for nurses?
Could you describe that situation in your own words? (Possible Prompts: From your perspective, what was important about that particular situation versus other situations? In what way was it important or unimportant who was involved? Did it matter when this situation occurred? In what way were particular features of the situation important or unimportant to you?)

What is it that makes such situations ethical problems?
Can you describe what it was that made that situation an ethical problem? (Possible Prompts: What was the problem that the situation caused for you as a nurse? In what way was it problematic to you? (e.g. decision to make; conflict; etc.) What alternatives did you see yourself to have, if any? In what way was the problem an ethical problem for you? (e.g. Were any beliefs or values involved?)

How does the nurse act upon such problems?
Can you describe the process you used to work through this problem? (Possible Prompts: How did you analyse or think through the problem. In other words, how did you move from a problem to a decision of what to do?)

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What does that acting upon look like?
Once you had decided on a solution to the problem, what did you decide to do? (Possible Prompts: How did you decide how to bring about the solution you’d decided on? Were there any factors that helped you decide on particular actions? Can you tell me what particular things you did to bring about the solution you decided upon?)

What are the things that help the nurse in acting upon these problems?
What helped you act when you encounter such problems? (Possible prompts: Were there any things about you in particular that assisted you in resolving such problems and, if so, what were they? How did they assist you? Were there any experiences you had had that you believed contributed to your ability to resolve such problems and, if so, what were they? How did they assist you? Were there any attributes of the clinical setting that were helpful to you in resolving such problems and, if so, what were they? How were they helpful?)

What are the things that hinder the nurse in getting through these dilemmas?
What hindered you in resolving problems such as we have discussed? (Possible prompts: Were there any attributes of the clinical setting that got in the way of your resolving the problems and, if so, what were they? How did they hinder you? Did any of your previous experiences hinder you in resolving such problems and, if so, what were they? How did they hinder you? Did any of your own attributes hinder you in resolving such dilemmas at times and, if so, what were they? How did they hinder you?)

Can you describe another type of situation that commonly involves ethical problems for you in which you have acted? We’ve discussed one type of situation that you’ve viewed as problematic and in which you’ve acted. Is there another type of situation which you found to be problematic and, if so, can you describe that situation in your own words? (Return to first section of interview schedule, work through questions above in sequence. Repeat this sequence if indicated.)
Can you describe a type of situation that commonly involves ethical problems for you in which you have not acted? Have you also experienced ethical problems in which you didn’t act and, if so, could you describe the situation in your own words? (Return to first section of interview schedule, work through questions above in sequence).

Is there anything else you would like to add?