ETHICAL PROBLEMS ENCOUNTERED BY
PUBLIC HEALTH NURSING ADMINISTRATORS

by

ALLISON JEAN CUTLER
B.S.N., The University of British Columbia, 1977

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING
in
THE FACULTY OF GRADUATE STUDIES
The School of Nursing

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
August 1992
© Allison Jean Cutler, 1992
In presenting this thesis in partial fulfilment of the requirements for an advanced
degree at the University of British Columbia, I agree that the Library shall make it
freely available for reference and study. I further agree that permission for extensive
copying of this thesis for scholarly purposes may be granted by the head of my
department or by his or her representatives. It is understood that copying or
publication of this thesis for financial gain shall not be allowed without my written
permission.

Department of **Graduate Studies/Nursing**
The University of British Columbia
Vancouver, Canada

Date **Aug 31, 92**
Abstract

The intent of this study was to explore the ethical problems encountered in public health nursing administration. A qualitative study, incorporating critical incident design, was conducted. The data was collected during audio-taped interviews with twenty public health nursing administrators.

The data were analyzed, utilizing the technique of content analysis, to identify common themes. Themes were identified in relation to the ethical problems experienced, the public health administrators' responses to the ethical problem, and the variables which influenced the public health administrators' experience of the problem.

The themes which emerged in relation to the ethical problems experienced were categorized according to the sources of nursing obligations, as identified by the Canadian Nurses Association [CNA] (1991). These obligations included clients, nursing roles and responsibilities, nursing ethics and society, and the nursing profession. The majority of ethical problems related to nursing obligations to clients and nursing roles and responsibilities. One ethical problem was identified in relation to nursing ethics and society; no problems were identified in relation to the nursing profession. Three of the participants did not perceive that they had experienced an ethical problem in their administrative practice in the past year.
The participants' responses were categorized according to how they acted, felt or thought about the ethical problem they experienced. The responses included stress, regret and uncertainty, utilization of a decision making approach, values clarification, failure to act, and the use of personal and external resources. The variables which influenced the participants' experience of the ethical problem were categorized according to personal, professional, organizational, and system variables.

The findings indicated that: the public health nursing administrators who participated in this study were able to identify ethical problems in their practice and to retrospectively analyze their experiences; the majority of public health nursing administrators in this study identified ethical problems related to lack of autonomy and conflicting role obligations; the public health nursing administrators all found the experience of the ethical problem difficult; the majority of public health nursing administrators did not feel supported in their experience of the ethical problem; the responses of public health nursing administrators showed a lack of systematic referral to ethical principles as they worked to resolve the problem; and organizational factors existed which made the experience of the ethical problem particularly difficult for public health nursing administrators who held their position on an acting basis.
Implications for nursing practice, education and research arising from these findings were outlined.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background to the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Significance</td>
<td>3</td>
</tr>
<tr>
<td>Conceptual Framework</td>
<td>4</td>
</tr>
<tr>
<td>Problem Statement</td>
<td>4</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>5</td>
</tr>
<tr>
<td>Research Questions</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>6</td>
</tr>
<tr>
<td>Assumptions</td>
<td>6</td>
</tr>
<tr>
<td>Limitations</td>
<td>7</td>
</tr>
<tr>
<td>Summary</td>
<td>7</td>
</tr>
<tr>
<td>CHAPTER TWO: LITERATURE REVIEW</td>
<td>8</td>
</tr>
<tr>
<td>Ethics</td>
<td>8</td>
</tr>
<tr>
<td>Ethical Theories</td>
<td>9</td>
</tr>
<tr>
<td>Ethical Principles</td>
<td>10</td>
</tr>
<tr>
<td>Autonomy</td>
<td>11</td>
</tr>
<tr>
<td>Beneficence</td>
<td>12</td>
</tr>
<tr>
<td>Justice</td>
<td>13</td>
</tr>
<tr>
<td>Ethical Approaches</td>
<td>15</td>
</tr>
<tr>
<td>Egoism</td>
<td>15</td>
</tr>
<tr>
<td>Deontology</td>
<td>15</td>
</tr>
<tr>
<td>Utilitarianism</td>
<td>17</td>
</tr>
<tr>
<td>Ethics of Health Care</td>
<td>18</td>
</tr>
<tr>
<td>Common Bioethical Issues</td>
<td>19</td>
</tr>
<tr>
<td>Nursing Ethics</td>
<td>23</td>
</tr>
<tr>
<td>Ethical Problems</td>
<td>25</td>
</tr>
<tr>
<td>Ethical Decision Making</td>
<td>30</td>
</tr>
<tr>
<td>Frameworks for ethical decision making</td>
<td>33</td>
</tr>
<tr>
<td>Moral Basis of Nursing</td>
<td>34</td>
</tr>
<tr>
<td>Codes of ethics for nursing</td>
<td>34</td>
</tr>
<tr>
<td>Public Health Nursing</td>
<td>35</td>
</tr>
<tr>
<td>Research and Public Health Nursing</td>
<td>36</td>
</tr>
<tr>
<td>Research Administration</td>
<td>38</td>
</tr>
<tr>
<td>Research and Nursing Administration</td>
<td>40</td>
</tr>
<tr>
<td>Research and Public Health Nursing Administration</td>
<td>42</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Years of Experience in Nursing, Public Health Nursing, and Public Health Nursing Administration</td>
<td>56</td>
</tr>
<tr>
<td>2: Comparison of Years of Nursing Experience Between Public Health Nursing Administrators and Public Health Nursing Assistant Administrators</td>
<td>56</td>
</tr>
<tr>
<td>3: Educational Preparation of Participants</td>
<td>56</td>
</tr>
<tr>
<td>4: Status of Position Held by Participant</td>
<td>57</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

I wish to acknowledge the special people who contributed to this project. Many thanks to the Public Health Nursing Administrators who took time from their busy schedules to share their experiences with me; to my thesis committee, Janet Ericksen, Ray Thompson, and Angela Henderson who provided support and guidance as well as challenging me to clarify my ideas; to my husband, Ross, and my children, Mike and Erin, who cheerfully adjusted to my frequent absences; and to my parents, David and Marie, who instilled in me the desire for life long learning.
CHAPTER ONE

Introduction

Background to the Problem

Public health nursing is an art and science that synthesizes knowledge from the public health sciences and professional nursing theories (Canadian Public Health Association [CPHA], 1990). The context of public health nursing practice is complex, including a broad focus of care (communities, groups, families and individuals across their lifespan) as well as a focus on the variables that affect health (lifestyle, family interaction patterns, community resources, economic and social factors, and public policy) (Aroskar, 1979; CPHA, 1990). Public health nurses experience ethical problems in their everyday work. Issues such as health inequities and confidentiality, as well as the conflicting priorities which multidisciplinary team members assign to ethical principles, are potentially problematic.

Nursing is a moral art (Curtin, 1979). It involves the seeking of good, and it involves our relationship with other human beings (Curtin, 1979). As such, it is not surprising then, that nurses face complex ethical issues on a daily basis. Levine (1977) stated that "to be a nurse requires the willing assumption of ethical responsibility in every
dimension of practice" (p. 845).


Although it is acknowledged that nurses in all practice settings experience ethical problems, there has been little focus on the ethical problems faced by public health nurses (Aroskar, 1979, 1989; Duncan, 1989). In the author's experience, as a public health nursing administrator ethical problems have been encountered in relation to staff competence, allocation of resources, and program and policy issues. These problems led to a questioning of what ethical issues were facing other public health nursing administrators and how other public health nursing administrators were dealing with ethical problems.

Nursing research on ethical problems of nursing administrators, thus far, has focused on ethical problems, ethical dilemmas, and ethical decision making amongst nurse administrators in acute care settings (Sietsema & Spradley, 1987; Youell, 1984, 1986). There are significant
differences in the nature of nursing practiced in public health settings and acute care settings. Therefore, differences exist in the nature of nursing administrative practices in these settings as well. The nature of the nursing role in public health is more autonomous and, in public health, the client includes individuals, families, and the community. It follows, then, that the nature of ethical problems experienced in public health nursing administration are different than those experienced by nursing administrators in acute care settings. There is no nursing research focused on the ethical problems experienced by public health nursing administrators. Therefore, this study focused on the ethical problems encountered in public health nursing administration.

Significance

It is intended that this study will contribute to a developing awareness of the ethical dimension of public health nursing administrative practice. Theoretically, this will enhance the growing body of knowledge related to ethical issues and provide further questions for research. Practically, the results of this study will provide useful insights to assist public health nursing administrators in dealing with ethical problems. Also, the information provided by this study will be useful in the educational preparation of public health nursing administrators.
Conceptual Framework

Curtin's (1978) model for critical ethical analysis has been used as the conceptual framework for this study. Duncan (1989) utilized Curtin's model in her study on ethical conflict and resolution in public health nursing practice. As this study is an adaptation of Duncan's study the same conceptual framework has been chosen.

Curtin's model identifies six factors which should always be considered in the analysis of ethical problems. These factors include the background information which is relevant to the situation of concern, identification of the ethical components of the problem, the ethical agents or persons involved in the decision making, identification of options, application of ethical principles, and resolution. As such, this model lends itself well to the research questions. In this study Curtin's (1978) model was utilized to identify the ethical components of the problems described by the nursing administrators, the resources used, and the factors influencing the public health nursing administrators' experience of the problem.

Problem Statement

Public health nursing administrators hold key positions within community health organizations and, as such, have the potential to impact on nurses, nursing practice, health care, and health policy. Public health nursing
administrators experience ethical problems and are in a position to set an ethical climate for nursing staff. It is, therefore, important to understand public health nursing administrators' perceptions of the ethical dimensions of their administrative practice. No research to date exists on the specific ethical problems of public health nursing administrators.

**Purpose of the Study**

The purpose of this study is to explore, from the perspective of public health nursing administrators, the ethical problems experienced in public health nursing administration, the responses of public health nursing administrators to ethical problems and the variables influencing the public health nursing administrators' experience of the ethical problem.

**Research Questions**

1. What ethical problems do public health nursing administrators encounter in their administrative nursing practice?
2. What are the public health nursing administrators' responses to these problems?
3. What variables influence the public health nursing administrators' experience of the problem?
Definition of Terms

Public health nursing

An art and a science that synthesizes knowledge from the public health sciences and professional nursing theories. Its goal is to promote and preserve the health of populations and is directed to communities, groups, families and individuals across their life span, in a continuous rather than episodic process. The main focus of public health nursing is health promotion, illness and injury prevention, and health maintenance (CPHA, 1990, p. 3, 19).

Public health nursing administrator

A nurse working in a provincial health unit in the position of Public Health Nursing Administrator or Public Health Nursing Assistant Administrator. The position may be held on a permanent or acting basis.

Ethical problem

Any problem identified as ethical in nature by the public health nursing administrator.

Response

The ways in which public health nursing administrators act, think, or feel about ethical problems.

Assumptions

1. Public health nursing administrators experience ethical problems.
2. Public health nursing administrators understand the
concept of ethical problems.

3. Public health nursing administrators can accurately recall their experience of an ethical problem.

4. Public health nursing administrators can retrospectively analyze their response to an ethical problem.

5. Public health nursing administrators will truthfully respond to the interview questions.

Limitations

The generalizability of this study is limited by the fact that the sample consists of public health nursing administrators working in provincial health units. The findings of this study cannot be generalized to public health nurse administrators who work in other settings.

Summary

In this chapter, the research study has been introduced. This introduction included a discussion of the background to the problem, the proposed significance of the study, the conceptual framework, the problem statement, purpose of the study, research questions, definition of terms, assumptions, and limitations.
CHAPTER TWO

Review of Selected Literature

Introduction

The literature review included the concepts of ethics, health care ethics or bioethics, nursing ethics and ethical problems. Research in the area of nursing ethics, in general, and ethics in relation to public health nursing and public health nursing administration, specifically, was reviewed.

Ethics

Ethics is a branch of philosophy known as moral philosophy (Frankena, 1973). Ethics is the systematic examination of the moral life and is designed to illuminate what we ought to do by asking us to consider and reconsider our ordinary actions, judgement, and justifications (Beauchamp & Childress, 1983). According to Benjamin and Curtis (1986) ethics is "an attempt to formulate and justify systematic responses to the following question: What, all things considered, ought to be done in a given situation?" (p. 9). The following themes can be identified within the definitions of ethics found in the literature: ethics is concerned with morality and ethical theory, ethics encompasses reasoned thinking and moral justification,
ethics requires a decision or action based on moral reasoning (Silva, 1990).

The word "ethics" often becomes synonymous with the word "morals". In the broadest sense, these two words refer to conduct, character, and motives involved in moral acts and include the notion of approval or disapproval of a given conduct, character, or motive that we describe by such words as good, desirable, right, and worthy, or conversely by such words as bad, undesirable, wrong, evil, and unworthy (Davis & Aroskar, 1991).

Differences between morality and ethics have been noted by several authors (Jameton, 1984; Thompson & Thompson, 1985). According to Thompson & Thompson (1985) morality consists of what a person ought to do in order to conform to acceptable social standards, whereas ethics consists of the philosophical reasons for and against the moral ought and ought nots proposed by society. Jameton (1984) used the terms professional and personal to contrast ethics and morals. He identified ethics as the publicly stated and formal sets of rules and values, such as a professional code of ethics, while morals are the set of values to which one is personally committed.

**Ethical Theories**

Within the field of ethics three categories of ethics can be distinguished. These are referred to as descriptive ethics, meta-ethics, and normative ethics (Frankena, 1973).
Descriptive ethics refers to empirical inquiry of a historical or scientific nature (Frankena, 1973). It is a factual investigation of moral behaviour and beliefs. Anthropologists, sociologists, psychologists, and historians determine whether, and in what ways, moral attitudes and codes differ from society to society (Beauchamp & Childress, 1983).

Meta-ethics, also called analytical or critical ethics, tries to answer logical, epistemological, or semantical questions such as "What is the meaning or use of the expressions "morally right" or "good"? How can ethical and value judgement be established or justified?" (Frankena, 1973, p. 4). This ethical field involves analysis of crucial ethical terms such as "right", "obligation", "virtue", and "responsibility" (Beauchamp & Childress, 1983, p. 8).

Normative ethics prescribes what ought to be done, what is good, right, or obligatory (Frankena, 1973). Normative ethical theories allow us "to formulate and to defend a system of fundamental moral principles and rules that determine which actions are right and which are wrong" (Beauchamp & Childress, 1983, p. 8). Ideally, normative theory will provide us with a complete set of action-guides which are universally valid (Beauchamp & Childress, 1983).

Ethical Principles

A number of ethical principles can be identified in the
literature. The principles of autonomy, beneficence, and justice are discussed here.

**Autonomy.**

Autonomy is based on the idea that individuals are self-directing and therefore capable of choosing and acting upon decisions they themselves have decided on (Fry, 1983). An autonomous decision is based on the individual's values, utilizes adequate information and understanding, is free from coercion or restraint, and is based on reason and deliberation (Wright, 1987). An autonomous action is one which results from an autonomous decision.

To respect persons as autonomous individuals is to acknowledge their personal rights to make choices and act according to individual determinations. Respect for persons requires that each individual be treated in consideration of his or her uniqueness and as an equal to every other individual, and that special justification be required for interference with an individual's own purpose, privacy, or behaviour (Jonsen & Butler, 1975).

This principle requires that a minimum consideration in decision-making affecting an individual is that the individual's own values and goals be considered in any major decision that affect his present or future welfare (Davis & Aroskar, 1991). Paternalism in health care is seen when health professionals or others make decisions for a patient that they consider to be in the patient's best interest,
with no consideration of the individual patient's own values and goals (Davis & Aroskar, 1991).

**Beneficence.**

Beneficence may be viewed on a continuum extending from noninfliction of harm (nonmaleficence) to benefitting others (positive beneficence) (Davis & Aroskar, 1991). According to Frankena (1973) the principle of beneficence states that "one ought not to inflict evil or harm, one ought to prevent evil or harm, one ought to remove evil, one ought to do or promote good" (p. 47). The duty not to inflict evil or harm takes precedence over the other three aspects, with other things being equal in a situation.

Beauchamp and Childress (1983) treat nonmaleficence and beneficence as two separate principles that indicate duties and moral obligations. Nonmaleficence is seen as the prohibition of intentional harm except in special circumstances and as requiring justification of risks by the probable benefits to be gained. This position is similar to Frankena's (1973). Beauchamp and Childress (1983) also take the position that nonmaleficence requires that agents such as health care professionals be thoughtful and take careful actions.

The beneficence principle requires the provision of benefits and a balancing of harms and benefits, as defined by the individual (Beauchamp & Childress, 1983). Benefits are considered to have positive value that promotes health.
or welfare while risks refer to possible future harms (Davis & Aroskar, 1991). Sometimes when maximizing benefits and minimizing risk of harm, there are also questions of justice.

**Justice.**

Simply stated, justice means giving others their due (Jameton, 1984). There are essentially two principles of justice (Beauchamp & Childress, 1983). Attributed to Aristotle, the formal principle of justice holds that equals ought to be treated equally and unequals unequally; in proportion to their relevant differences. Although the formal principle of justice is useful, it is also limiting because it does not specify who is equal and who is unequal, and what are morally relevant differences among persons that allow one to determine what each person is due.

The material principles of justice are useful in overcoming these problems. The material principles assume that not all persons are equal for the purpose of distributing all of the goods and services in society. Material principles include an equal share to each person, according to effort, according to societal contribution, according to need, and according to free market exchange (Beauchamp & Childress, 1983).

Justice has three primary areas of application. Distributive justice focuses on the allocation of goods and services. Retributive justice is primarily concerned with
punishment for wrongdoing. Procedural justice focuses on how things are done independent of final outcome (Jameton, 1984).

The principles of distributive justice are most applicable for health care. Three dominant theoretical perspectives of distributive justice can be identified. These are libertarian, utilitarian, and egalitarian. Each of these theories gives priority to certain ethical principles over others. The libertarian views individuals as having inherent worth and as having certain moral rights. Free choice is a central concept, and libertarians believe that people freely choose to contribute as they wish to economic matters and that this freedom should not be interfered with.

The utilitarian perspective can be reduced to two major theses; an action is right if it leads to the greatest possible balance of good consequences or to the least possible balance of bad consequences for all persons involved with the action, and that which maximizes the good determines what is right to do.

Equality plays a central role in egalitarian theories and thus egalitarians place high value on the concept of justice as equality. Rawls (1971), the major theorist advocating this position, equates justice with fairness. He has proposed two principles. First, each person is to have an equal right to basic liberties. Second, social and
economic inequities should be arranged to the greatest benefit of the least well off, and there must be equal opportunity for all to gain the advantages of treating people unequally (Veatch & Fry, 1987).

**Ethical Approaches**

Health care ethics, in general, and nursing ethics, in particular, are based on normative ethics. This discussion therefore focuses on normative ethical theories. The traditional positions or theories of egoism, deontology, and utilitarianism can be found within normative ethics.

**Egoism.**

The ethical egoist believes that an individual's one and only basic obligation is to promote for himself the greatest possible balance of good over evil (Frankena, 1973). When answering the question of what is the morally right thing to do, the ethical egoist says that something is good because the individual desires it. The right act is the one that is most comfortable for the individual (Davis & Aroskar, 1991). This approach is not seen as relevant for health care because in health care the focus is on doing good for others.

**Deontology.**

The deontologic or formalist ethical approach suggests that "features of some acts other than their consequences make them right or wrong" (Beauchamp & Childress, 1983, p. 33). The rightness or wrongness of actions depends on more
than the agent's pleasure or the consequences of the proposed action, it depends on the nature or form of these actions in terms of their inherent moral significance, such as keeping a promise (Davis & Aroskar, 1991). According to this approach, one should act according to principles, rules, or duties.

Immanuel Kant, the major deontologist, originated this approach. Kant (1981) ascribed less significance to the consequences of actions and emphasized the duty to treat people as ends, never as means to an end. He maintained that persons have absolute value and that the principle that should guide our actions is to be found in the ability to make an action universal (categorical imperatives). Kant proposed that rational beings should always ask the question "How would things stand if my maxim became universal law?" (Storch, 1982a, p. 27). Kant (1981) stated that these categorical imperatives are unconditional commands, morally necessary, and obligatory under any circumstances.

There are two kinds of deontology, act and rule. The difference focuses on whether moral demands arising from duty can be applied to specific acts in specific situations or to rules of conduct that determine the rightness or wrongness of an act. Act-deontological theories maintain that the basic judgments of obligation are all purely particular ones like "In this situation I should do so and so" (Frankena, 1973, p. 15). Rule deontologists hold that
the standard of right and wrong consist of one or more rules such as "Always tell the truth".

Utilitarianism.

Utilitarianism, the theory of utility, defines "good" as happiness or pleasure, and "right" as maximizing the greatest good and least amount of harm for the greatest number of persons. This position assumes that one can weigh and measure harm and benefit and come out with the greatest possible balance of good over evil for most people. Each individual counts as one in the utilitarian approach (Davis & Aroskar, 1991).

There are two types of utilitarianism - act and rule. The difference focuses on whether the principle of utility is to be applied to specific acts in specific situations or to rules of conduct that determine the rightness or wrongness of an act. In act utilitarianism, specific acts in specific situations are viewed as unique, and the principle of utility is applied directly to each act. In act utilitarianism, one must ask "What effect will my doing this act in this situation have on the general balance of good over evil?" not "What effect will everyone's doing this kind of act in this kind of situation have on the general balance of good over evil?" (Frankena, 1973, p. 30).

In rule utilitarianism, the principle of utility is applied to the rule and not to the individual act. A rule utilitarian asks "What would happen if everyone were to do
that in such cases?" not "What will happen if I do that in this case?" (Frankena, 1973, p. 30).

John Stuart Mill has presented the major historical arguments for the classical utilitarian approach. According to Mill (1979) the morally correct action is determined by what he called the greatest happiness principle: "...actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness" (p. 7). Today this principle is more frequently stated as "Do the greatest good for the greatest number of people" (Wright, 1987).

Many forms of rule utilitarianism and rule deontology can lead to identical rules and action, albeit for different reasons (Beauchamp & Childress, 1983). According to Storch (1982a) the "actual selection of a theory is not as important as the process of investigating, valuing, and choosing an approach, through principles or theory, that best matches the individual's work situation and assists in understanding of the complexities of a dilemma" (p. 28).

Ethics of Health Care

Health care ethics, also called bioethics, "can be defined as the systematic study of human conduct in the area of...health care, insofar as this conduct is examined in the light of moral values and principles" (Reich, 1982, p. xix). The ethics of health care addresses four interrelated areas:
issues in clinical practice, allocation of scarce resources, human experimentation, and health policy (Davis & Aroskar, 1991). The task of health care ethics is neither to discover some new moral principles on which to build a theoretical ethical system nor to evolve new approaches to ethical reasoning, but to prepare the ground for the application of the established general moral rules (Closer, 1975).

The origin of systematic work in health care ethics is fairly recent, however many issues in this applied field have been debated for decades and, in some cases, for centuries. Professional codes of ethics have evolved from this reflection on problems of health care ethics (Beauchamp & Childress, 1983).

**Common Bioethical Issues**

The literature on bioethics commonly identified several major issues. The issues of confidentiality, truthtelling, informed consent, and refusal of treatment are briefly discussed here.

Rules of confidentiality were mentioned in the earliest professional codes. Confidentiality "is understood as a means of controlling access to sensitive information that one party has disclosed to another party with the understanding that the information will be kept in confidence" (Beauchamp & Walters, 1989, p. 375). In health care relationships, however, the duty to observe the rule of
confidentiality is not always an absolute duty, it may be overridden when in conflict with other duties that are morally stronger. For example when the duty to preserve life outweighs the duty to respect confidential information concerning self-destructive wishes of the client or threatened harm against others.

The duty to tell the truth (veracity) and not lie or deceive people, at times, in health care, becomes problematic. Several arguments were usually given for a duty to tell the truth (Beauchamp & Childress, 1983). One argument claimed that we tell the truth because this is part of the respect we owe persons. Because we respect persons and their autonomy we have a duty to veracity. Another argument claimed that relationships of trust are necessary for cooperation between clients and health professionals. Thus truthful relationships must be maintained in order to strengthen and maintain therapeutic relationships between clients and health professionals. Another argument claimed that the duty of veracity is related to the duty of promise keeping. Therefore, in order to maintain the implicit contract between the client and the health professional, the duty of veracity must be upheld.

However, health professionals often have difficulty in observing a duty of veracity. Information is sometimes withheld from the client or the client is deceived because the health professional may think certain information will
cause the client harm. For example, when a diagnosis of a terminal illness would cause the client anxiety or lead to an act of self-destruction, a physician may withhold the information that would cause the harm.

Informed consent is primarily grounded in the ethical principle of autonomy. This means that individuals have the right to information and, on the basis of this input, the right to agree or to refuse to participate in research or to undergo the treatment being proposed. As previously discussed, autonomy means that persons have the right to determine their course of action on the basis of a plan which they have developed for themselves. From an ethical perspective, health professionals are obligated to respect the clients' decisions even in those situations where they disagree with the client. There are complex exceptions to these general rules, such as when parents decide on a course of action for their child which is harmful and might even lead to death. Another exception can be found in emergency situations where the health professionals have the primary obligation to treat. The situation also becomes problematic when there is concern that the individual is physically or mentally incapacitated and unable to make a reasonable decision for themselves.

The literature discussed situations in which the client's refusal of treatment becomes problematic for health professionals. According to the principles of autonomy,
veracity, and informed consent it seems logical that an individual has a right to accept or reject the interventions offered by health professionals. However, this is not always the case, particularly when the refusal of treatment will likely lead to death. This conflict was discussed in the literature as the conflict between autonomy and paternalism. According to Reich (1982), an examination of the right to refuse treatment necessitated an examination of the conflicting rights of the individual versus the collective rights of society. These collective rights included:

1. the need to protect people from their own imprudence,
2. maintaining a healthy population to support society,
3. avoiding harm to third parties,
4. minimizing health care and other costs,
5. safeguarding public morality and decency, and
6. reinforcing the principle the life is sacred (p. 1499-1500).

In recent years ethical issues related to health promotion have been given attention in the literature (Anderson & Fox, 1987; Becker, 1986; Burdine, McLeroy, & Gottlieb, 1987; Doxiadis, 1987; Guidotti, 1989). In Canada, Epp's (1986) paper, Achieving health for all: A framework for health promotion, has had a significant impact on political and professional acceptance of the ideals of health promotion. In contrast to the life and death dilemmas frequently associated with health care technology, the dilemmas associated with health promotion are of a more social
nature. Doxiadis (1987) identifies value conflicts in social policies, paternalism in health education, conflicts between personal and public health goals, and the allocation of health care resources as ethical issues related to health promotion.

**Nursing Ethics**

Nursing ethics are part of the larger field of health care ethics. As noted earlier, ethical problems are not new or unique to nursing. Lamb (1981), in studying the historical evolution of nursing ethics in Canada, found that nursing ethics initially focused on the service ideal, duty to the community, and the individual behaviour of nurses and, over the years, has shifted focus to person-centered care, patient rights, and quality of care.

Within the literature controversy exists as to the scope of nursing ethics. Some believe that nursing ethics signifies the uniqueness of moral problems that nurses face and reflects the uniqueness of moral reasoning in women (Gilligan, 1987); others argue that there is little that is morally unique to nurses (Veatch & Fry, 1987). Veatch (1981) stated that "nursing ethics is a legitimate, if very limited, term referring to a field that is a sub-category of medical ethics" (p. 17). Other authors have stated that nursing ethics is clearly distinct from medical ethics (Levine-Ariff & Groh, 1990).
Aroskar (1990) defined nursing ethics as "systematic reflection on what is the right conduct in nursing education, service, and research in relation to what we do ourselves, to each other, to other individuals and groups, and to environments in which nursing is practiced" (p. 36). Lamb (1981) stated that nursing ethics refers to "beliefs about the moral values, ideals, virtues, obligations, and principles identified by nurses as important" (p. 3). Bishop and Scudder (1987) contended that the "moral sense of nursing practice is affirmed as the primary focus of nursing ethics" (p. 34). Support for this argument is found in the literature (Baker, 1987; Donahue, 1990; Fowler; 1990).

Yarling and McElmurry (1986) urged that nursing ethics be viewed as reform ethics. They argued that nurses are often not free to be moral, and that the fundamental moral problem of nursing is a consequence of the structure and policies of the social institution in which nursing is practiced. They contend that nurses should focus on the reform of the health care system rather than on individual morality. The argument that nurses are not free moral agents is supported elsewhere in the literature (Davis & Aroskar, 1978; Curtin, 1980).

The concept of caring is important in any discussion of nursing ethics. Caring is a form of doing good and avoiding harm and so is central to nursing ethics (Bandman & Bandman, 1990). Gadow (1985) contends that "caring is attending to
the 'objectness' of persons without reducing them to the moral status of objects" (p. 33-34). Accordingly Gilligan (1987) asserted that the 'ethic of caring' is unique to women and develops differently than the predominantly male 'ethic of justice'. Fry (1988) stated that an ethic of caring serves as a universal value that guides nursing practice.

The role of nurses as advocates is also central to nursing ethics (Curtin, 1979; Gadow, 1980a, 1980b; Murphy, 1983). Gadow (1980a) proposed that existential advocacy is the essence of nursing. To Gadow (1980a, 1980b) advocacy means that individuals are assisted by nursing to authentically exercise their freedom of self-determination and that the nurse is morally aligned with the patient rather than with the physician, family or hospital. Curtin (1979) stated that the "philosophical foundation and ideal of nursing is the nurse as advocate" (p 2).

Ethical Problems

Ethical problems arise for nurses in fulfilling the moral sense of nursing practice. The literature presents various conceptualizations of ethical problems, conflicts and dilemmas (CNA, 1991; Curtin, 1982; Davis & Aroskar, 1991; Jameton, 1984; Storch, 1982a). Curtin (1982) defined ethical problems as problems which cannot be resolved solely through an appeal to empirical data; are inherently perplexing with conflict of values and uncertainty about the
amount or type of information needed to make a decision; and the answer to which will have profound, far-reaching and often unknown effects.

The CNA (1991) identified three distinct categories of ethical problems: ethical violations which "involve the neglect of moral obligations"; ethical dilemmas which "arise when ethical reasons both for and against a particular course of action are present"; and ethical distress which "occurs when nurses experience the imposition of practices that provoke feelings of guilt, concern or distaste" (p. ii-iii).

Jameton (1984) sorted ethical problems into three types, moral uncertainty, moral dilemmas, and moral distress. Moral uncertainty "arises when one is unsure of what moral principles or values apply, or even what the moral problem is" (p. 6). Moral dilemmas "arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" (p. 6). Moral distress "arises when one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6).

Aroskar (1980a) stated that an ethical dilemma "involves either a choice between equally unsatisfactory alternatives or a difficult problem that seems to have no satisfactory solution" (p. 658). Storch (1982a) defined an ethical dilemma as "a choice between two equally undesirable
Smith and Davis (1980) viewed ethical dilemmas in the context of conflict. They suggested that dilemmas arise in the following situations:

1. A conflict between two ethical principles one holds.
2. A conflict between two possible actions in which (a) there are some, not conclusive, reasons favoring a particular course of action and (b) some, not conclusive, reasons against the same course of action.
3. A conflict between a demand for action and the need for reflection in a situation.
4. A conflict between two equally unsatisfactory alternatives.
5. A conflict between one's ethical principles and one's role obligations (p. 1463-1464).

An ethical dilemma, thus, is a particular kind of ethical problem wherein there is a conflict of "right" choices.

Bergman (1973) stated that nurses face ethical problems on two levels, daily practice and policy levels. The literature provided many examples of both levels of ethical problems (Allen, 1974; Bandman & Bandman, 1990; Boyd, 1977; Bishop & Scuddcr, 1987; Davis, 1981, 1989).

Ethical problems were also presented from the perspective of individual and consumer rights (Benoliel, 1983; Storch, 1977, 1982a; Wright, 1987). Storch (1982a) defined rights as justified claims that persons or groups may make upon each other or society. Storch (1982a) contended that the concept of rights spans the related, but different, disciplines of ethics and law and is therefore of central importance to ethics.
Through nursing research, clinical nurses' perceptions of ethical problems, dilemmas, and decision-making have been examined (Allen, 1974; Boyd, 1977; Davis, 1981, 1989; Murphy, 1983, 1985; Scanlon & Fleming, 1990). Murphy (1983) studied nurses' responses when confronted with hypothetical dilemmas which pitted patients' rights and interests against those of the institution and the physician. Murphy (1983) identified three models of nurse response; the bureaucratic model, the physician-advocate model, and the patient-advocate model. In the bureaucratic model the nurses' primary loyalty was to the institution. In this view, the interests of patients could be sacrificed by the nurse in the interest of keeping the peace and enabling the institution to function without disruption. Those nurses who followed the physician-advocate model perceived themselves as accountable only to physicians. The purpose of nursing, in this model, was to follow doctors' orders and to promote the ends of science, research, or medical technology, perhaps at the expense of patients' rights. The model of patient-advocate had the lowest incidence. In this model nurses perceived themselves as having moral and legal accountability to the patient.

Murphy (1985) conducted another study in which she asked nurses to explain, in detail, the types of ethical dilemmas they experienced in clinical practice. Of the 800 cases studied, forty-nine percent were concerned with truth-
telling. The dilemmas associated with the right to refuse treatment (19%) and the prolongation of life (17%) ranked as second and third most prevalent categories. The finding of this study are supported by Allen (1974).

Boyd (1977) reported a survey in which nurses in Scottish hospitals identified care of terminally ill patients, deciding whether or not to resuscitate, and truth-telling as the main moral dilemmas arising from their nursing practice. Davis (1981) conducted a survey of 205 nurses in California to determine those ethical dilemmas that were particularly troublesome to them. The two most frequently cited dilemmas were prolonging life with heroic measures and unethical/incompetent activity of colleagues.

A more recent study of 100 Canadian nurses surveyed the types of ethical dilemmas faced by the nurses, the factors affecting such problems and the nurses' understanding of the concept (Davis, 1989). Twenty nine percent of the respondents reported weekly confrontations with ethical dilemmas, twenty nine percent reported monthly confrontation, and forty two percent reported that they rarely or never confronted ethical dilemmas. Davis found that the nurses definition of an ethical dilemma varied and that the respondents used their personal religious beliefs and the code of ethics as a guide in dealing with these dilemmas. Davis found that discrepancies existed between the definitions and understanding of the concept of ethical
dilemmas, the importance placed on ethical issues, and the number of ethical confrontations.

Nursing research has shown, that for some nurses, moral conflict may lead to moral distress (Fenton, 1988; Wilkinson, 1986). Moral distress is the disturbing emotional response which arises when one is required to act in a manner which violates personal beliefs and values about right and wrong (Wilkinson, 1986). Moral distress may affect the nurse's ability to care for the patient and may require a significant period of resolution. Moral distress has been identified as one reason that nurses choose to leave their jobs and occasionally to leave the profession (Fenton, 1988).

Lamb (1985) found that nurses perceived the negative effects of the multiple and conflicting loyalties existing within various nursing practice settings. Lamb found that these conflicting loyalties resulted in limitations on nurses' abilities to uphold the value of patient autonomy.

Ethical Decision-Making

Ethical decisions should be made on the basis of ethical theory and careful thought rather than on the basis of medical, practical, financial, religious, or legal criteria, though these types of criteria may influence decision making (Bunting & Webb, 1988). The degree to which these other factors should influence decision making is controversial and will vary between disciplines. For
example, a physician may base a decision primarily on medical factors while a lawyer may consider the legal aspects most important. An ethical decision-making system has the potential of offering a rigorous, rational methodology for resolving ethical problems (Hynes, 1980).

Ethical reasoning is the process of applying decision-making techniques to problems with an ethical component (Ericksen, 1989). The process of ethical reasoning is complex for nurses because they must examine their commitments at the same time that they act upon them in clinical practice (Jameton, 1984). However, as Jameton (1984) stated, "the process of ethical reflection can improve the quality of professional decisions, raise the level of communication with others, increase sensitivity to patients, and give one a sense of clarity and enlightenment about one's work" (p. 152).

Nursing research has shown that a rigorous and rational approach is not always utilized in nursing practice. Rodney (1987) undertook a master's thesis to explore nurses' perspectives in relation to one specific ethical issue, prolongation of life. Her study results showed a senseless or fruitless decision-making process. Inadequate involvement of the patient, inadequate involvement of the family, inadequate involvement of the nurse, and fragmentary team decision-making all contributed to nurses' concerns about a senseless decision making process (Rodney, 1987,
1989).

Rodney (1989) stated that throughout any of our efforts to implement ethical decision-making in nursing we must attend to the organizational climate for professional nursing practice. This means fostering ethical relationships between nurses and physicians and also between nurses and nursing administration (Aroskar, 1985; Rodney, 1989).

Nurses' level of moral development influences their decision-making (Crisham, 1981, 1985; Mahon & Fowler, 1979). Crisham (1981) found that education and previous experience with similar dilemmas increased the level of the nurse's moral responses. Ketefian (1981) found similar results and also found that strong professional role conceptions were related positively to both levels of education and moral reasoning.

Rest (1979) suggested that differences in moral judgement may be interpreted in terms of enriched versus impoverished environments. In the enriched environment, persons are encouraged to examine their views more thoroughly and systematically; this process leads to more complex and advanced, or higher, thinking. It is a role of nursing administrators and educators to foster the development of an enriched environment for ethical decision making.

Structures and mechanisms that have been suggested to
implement ethical decision-making include ethics rounds, institution ethics committees, and nursing ethics councils (Davis, 1982). In a recent study (Scanlon & Fleming, 1990) nurses were surveyed to determine how they were addressing ethical concerns in their practice. The methods identified included nursing meetings (66%), inservice education (18%), hospital committees (9%), individual discussion (9%), hospital ethics committee (9%), and interdisciplinary rounds (4%).

Frameworks for ethical decision-making.

Several frameworks for ethical decision making were presented in the literature (Aroskar, 1980b; Bergman, 1973; Bunting & Webb, 1988; Curtin, 1982; Levine-Ariff & Groh, 1990; Murphy & Murphy, 1976; Silva, 1990; Stanley, 1980; Sullivan & Brown, 1991b; Thompson & Thompson, 1985). Silva (1990) identified the criteria for validating decision-making frameworks as adequacy, consistency, coherence, comprehensiveness and practicality. Several frameworks are similar to the nursing process in that the nurse begins by identifying the major aspect of the problem, identifies and gathers additional information, generates and selects alternative courses of actions, implements decisions and evaluates outcomes (Bergman, 1973; Murphy & Murphy, 1976). Other frameworks are based on values clarification (Stanley, 1980; Thompson & Thompson, 1985).

Crisham (1985) presented an approach to ethical
decision making which she has termed the "MORAL model" (p. 28). The steps of Crisham's (1985) model include Massage
the dilemma, Outline options, Review criteria and resolve,
Affirm position and act, and Look back.

Recently, in the nursing literature, Sullivan and Brown
(1991b) described a model for decision making in ethical
problems which they called a "common sense" approach. The
authors stated that the model was not an attempt to apply a
specific ethical theoretical model but rather was inferred
from reflections on readings, cases, and personal
experiences, in nursing and in business, that focused on
ethical issues.

Moral Basis of Nursing

Codes of Ethics for Nursing

Nursing obligations are written in nursing codes of
ethics. According to Murphy (1985), a code of ethics for
nurses serves as a contract between society and the
profession by setting forth the values and ethical
principles that guide the clinical decisions of practicing
nurses. As Tate (1977) stated, "codes are not law but are
guides to all nurses in making critical decisions pertaining
to appropriate professional behaviour and actions" (p.
viii).

Codes, however, are merely guidelines that do not
always address the more troublesome issues inherent in the
ethical dimensions of practice and education. Thus, as Donahue (1990) stated "nurses cannot rely on codes of ethic to provide them with solutions or to prescribe correct actions to take when faced with ethical issues and dilemmas" (p. 580). Potential shortcomings of professional codes are frequently discussed in the literature (Beauchamp & Childress, 1983; Hunt & Arras, 1977; Steele & Harmon, 1979; Storch, 1982a; Wright, 1987).

Public Health Nursing

The terms public health nursing and community health nursing are often used interchangeably in the literature. However, it is currently accepted that the term community health nursing refers to all nurses who work in community settings. The term community health nurse encompasses public health, continuing care, occupational health, and federal health nurses. The term public health nurse refers, more specifically, to nurses who work in community settings, and whose main focus is health promotion, illness and injury prevention, and health maintenance.

Public health nursing is an art and science that synthesizes knowledge from the public health sciences and professional nursing theories (CPHA, 1990). As previously mentioned, the context of public health nursing practice is complex, including a broad focus of care as well as a focus on the variables that affect health (Aroskar, 1979; CPHA,
The ethical implications of social interventions (actions, planned or unplanned, which changes the characteristics of an individual or that changes the pattern of relationships between individuals), health promotion, the provision of care to aggregates versus individuals, as well as the allocation of scarce resources are issues which face public health nursing practitioners and administrators (Armstrong, 1987; Aroskar, 1979, 1989, 1990; Duncan, 1989; Fry, 1983; Jenkins, 1989; Lanik & Webb, 1989; Schultz, 1987).

Research and Public Health Nursing

Little nursing research has focused on the ethical problems experienced by public health nurses. Aroskar (1989) conducted the first such study which focused exclusively on ethical problems in community health nursing and how nurses dealt with these issues in their everyday practice. This descriptive study focused on the single most significant ethical problem identified by individual respondents in their practice, the ethical principles and values at stake and the types of resources used to deal with the problem. Questionnaires were sent to over 1000 staff nurses employed in community health agencies. Three hundred nineteen responses were used in analysis of the data. The majority of the respondents' caseloads were characterized by clients over the age of 65 years with long-term chronic illness. About 15% of the caseloads were identified as
primarily public health. Aroskar found that the most significant ethical problems described by respondents focused primarily on the individual client and advocacy for that individual. The categories of the most significant ethical problem included: when autonomy and beneficence conflict, when truth-telling and nonmaleficence conflict, and principles of distributive justice. The respondents identified religious values, life experience, laws, professional codes and common sense as sources of guidance. The respondents turned primarily to their nursing colleagues for assistance in dealing with significant ethical problems. They also used agency supervisors, administrators, friends, and family as resource people. As Aroskar noted, turning to agency supervisors and administrators for assistance was notable because close to half of the respondents reported a lack of administrative support for establishing and maintaining a working environment that enhanced quality of client care.

A master's thesis by Susan Duncan (1989) focused on ethical conflict and response in public health nursing practice. The sample included twenty three staff nurses and seven nurses in middle management positions. Based on this survey of thirty public health nurses, Duncan found that the ethical conflicts identified by the respondents could be categorized as: clients' rights (including ethical conflicts related to working with high-risk parents, adult clients
with mental health concerns, and adolescent clients); system interaction (including ethical conflicts related to health team relationships and the allocation of resources); and nurses' rights (including conflicts related to personal and professional rights and values). The category of clients' rights was the largest response category, and the category of system interaction included the responses of public health nurses in both staff and middle management positions.

Duncan (1989) concluded that the situations containing ethical dilemmas for public health nurses are potentially everyday occurrences, as opposed to being rare or sensational. She also found that although the conflicts faced by the respondents were not unique in themselves, the way in which the public health nurses experienced the conflicts may differ from nurses in other roles and settings. Duncan attributed this to the primary position of the public health nursing role within the health care system.

Nursing Administration

Nursing administrators are responsible for the effective and efficient delivery of organized nursing services within health care institutions and for the professional practice of its nursing personnel (CNA, 1988). The CNA (1991) Code of Ethics for Nursing charges nursing administrators with special ethical responsibilities that
flow from concern for present and future clients. Ethical action of nurse administrators implies client advocacy, equitable allocation of scarce resources and consideration of the nursing staff (Clatterbuck & Proulx, 1981; Fry, 1986; Silva, 1984; Storch, 1982b). According to Christensen (1988) nurse administrators have a responsibility to nursing staff for creating an ethical work environment in which nurses' human welfare is promoted. Christensen (1988) identified the components of an ethical framework for nursing administration as including "the use of a principled reasoning process, a moral commitment to the profession and to each other, and a primary consideration for human welfare with strategies to promote it" (p. 51). Sullivan and Brown (1991a) suggested a number of steps which may limit the number or intensity of ethical dilemmas experienced by nurse administrators. These steps include acting as a moral model; hiring, associating and consulting with moral people; stressing standards and the spirit of the law; and being committed.

Nurse administrators are faced with complex decisions that flow from their multiple loyalties to clients and families, staff and the organization which employs them. Ethical issues are becoming increasingly complex for nursing administrators because of escalating economic concerns such as a scarcity of resources, and increased attention to legal
concerns, such as human rights and informed consent (Jenkins, 1989).

Research and Nursing Administration

Nurse administrators have the potential to impact on nurses, nursing practice, health care and health policy. It is, therefore, important to develop an understanding of nurse administrators' perceptions of the ethical problems they face and the approaches and resources used to resolve these problems.

Youell (1984) studied the major ethical problems of nursing administrators and resources used by them to deal with these problems. In her research she conducted interviews with thirty one middle and senior line nursing administrators in five acute care urban general hospitals in Alberta. The nursing administrators in this study identified problems relating to patients, nursing staff, physicians, and the institution, with problems related to nursing staff being identified as the most difficult. These problems included competence, substance use, theft, and information sharing.

The resources used to deal with these problems were one's superiors, medical staff, peers, continuing education courses and workshops, literature, pastoral care services, personnel departments, and confidantes. However, even with the large number of resources listed, some participants felt a lack of resources or support for dilemmas faced.
The principles and values that participants listed as guiding their approach to ethical problems related to the categories of professional, personal, institutional, and general values, with the most common being centered around patient rights, individuality, respect, hospital philosophy/values, employee-related values, and personal beliefs/values. Youell (1984) noted that senior nursing administrators more frequently espoused institutional and general principles or values, while middle managers more frequently listed personal values.

When analyzing the approaches used by the administrators to deal with the problems Youell (1984) found that the approaches "revealed a lack of systematic referral by participants to ethical principles" (p. 82). Youell concluded that further education regarding ethics and the opportunity for mutual sharing of problems would be valuable. She also recommended that nursing administrators should continue to recognize their importance as role models of ethical behaviour and be willing to enhance their own skills and knowledge in order to be effective role models. Youell (1984) concluded that attention should be directed to further assessment of the adequacy of resources used by nursing administrators and that the vehicle of hospital ethic committees needs to be enhanced to meet nursing administrators' needs.

Sietsema and Spradley (1987) surveyed one hundred
twenty five hospital nurse executives. These nursing administrators experienced ethical dilemmas on a regular basis in a wide range of situations. The dilemmas most frequently cited were: staffing level and mix decisions, development and maintenance of care standards, and allocation and rationing of scarce resources. The respondents indicated that they rely on personal values (their own and those of administrative colleagues) to resolve these dilemmas. Sietsema and Spradley (1987) conclude that "the most critical thing nurse executives can do is discuss at meetings and in the nursing literature, the ethical premises on which they should build their practice" (p. 31).

Other studies, already discussed in this review, have implications for nursing administration as well (Fenton, 1988; Rodney, 1989). As these studies point out, moral distress may be a factor in job satisfaction and retention of nurses in clinical practice.

Research and Public Health Nursing Administration

The author was unable to locate any research focused specifically on ethical problems experienced by public health nursing administrators. However, the findings of Aroskar (1989) and Duncan (1989) have implications for public health nursing administration. As previously noted, Aroskar (1989) found that public health nurses turned to their agency supervisors and administrators as resource
people in dealing with ethical problems. Aroskar concluded that knowing the types of situations that respondents identified as major ethical problems provides public health administrators with clues as to ethical issues that community health nurses are confronting in their practice. Aroskar recommended that this information be used by agencies to develop an individualized needs assessment for staff development programs, for review of existing agency policy, and for making determination about development of new policies that take ethical problems into account.

Duncan (1989) included seven middle managers in her sample of thirty public health nurses. As previously discussed, these middle managers identified conflicts involving health care team relationships and the allocation of resources as significant. Duncan concluded that the support of administrators was important to public health nurses dealing with ethical problems. Also, because attempts to resolve many of the dilemmas were frustrated by the influence of external forces existing at the system level, the importance of public health nursing administration developing policies and organizational structures which support the staff is clear.

Summary

Literature related to ethics, nursing ethics, public health nursing and nursing administration was reviewed. The
literature showed that although ethical problems exist in all areas of nursing, little research to date has focused on ethical issues specific to public health nursing administration.
CHAPTER THREE

Methodology

Qualitative research theory guided the methodological approach of this study. This chapter describes the selection of participants, the data collection and data analysis process, reliability and validity of the study, and the ethical considerations.

Study Design

A qualitative study, incorporating critical incident design, was conducted. Qualitative research methods are defined as the "descriptive analytical investigations of the world of human experience" (Field & Morse, 1985, p. 125). Qualitative research "seeks to gain insight through discovering the meanings attached to a given phenomenon" (Burns & Grove, 1987, p. 75). The critical incident technique "is a method of gathering information about people's behaviours by an examination of specific incidents relating to the behaviour under investigation" (Roberts & Ogden Burke, 1989, p. 348). The critical incident is one which has had a significant impact on some outcome; it must make either a positive or negative contribution to the accomplishment of some activity of interest. The critical incident in this study was the ethical problem encountered,
in the past year, by the public health nursing administrator. The critical incident technique is compatible with Curtin's (1978) model, the conceptual framework for this study, in that it requires that background information be collected to develop the context of the incident.

The study design was adapted from a study completed by Duncan (1989). Duncan's study was also a qualitative study which utilized critical incident design. The populations varied somewhat between the two studies. This study focused specifically on public health nursing administrators. Duncan's study population included staff and administrative public health nurses, as well as nurses in specialty positions (such as school health). Duncan's interview guide was adapted to reflect this study's specific focus on the ethical problems experienced by public health administrators. Specifically, the public health nursing administrators were asked to recall an ethical problem they had experienced in their administrative practice.

Selection of Participants

A convenience sample was used. Convenience sampling is the selection of the most readily available persons as subjects (Polit & Hungler, 1989). Convenience sampling is consistent with the qualitative study design and also with the data collection method of critical incident technique.
This sampling technique was chosen because the researcher had access to the study population. The sample was limited to public health nursing administrators working in provincial health units. Public health nursing administrators working in other settings (such as municipal health departments or the federal health system) and in other areas of community health (such as continuing care and mental health) have a different perspective and, therefore, may experience different ethical problems. For these reasons the study population was strictly defined.

Criteria for Selection

The study population consisted of public health nursing administrators currently employed by the provincial Ministry of Health in the capacity of Public Health Nursing Administrator or Public Health Nursing Assistant Administrator. Both of these positions are responsible for the management of the Public Health Nursing program at the health unit level and it was, therefore, considered appropriate to include subjects who held either position. The subjects held the position on a permanent or acting basis. Public health nursing administrative positions are frequently held on an acting basis, often for long periods of time. It was, therefore, decided to include those who held administrative positions on an acting basis in the sample population. The sample pool size consisted of forty-four public health nursing administrators.
Selection Procedure

Prospective subjects were contacted by letter (Appendix A). The letter outlined the study and prospective subjects were asked to sign a consent form indicating their willingness to participate (Appendix B). All public health nursing administrators who met the sample criteria and who consented to participate were eligible to be included in the study.

Twenty four public health nursing administrators agreed to participate in the study. However, interviews could not be arranged with four of the prospective participants within the time frame of this study. Therefore, the actual sample size was twenty public health nursing administrators.

Data Collection

To obtain the data needed to answer the study questions, audio-taped interviews were used. Eight interviews were conducted in person and the remaining twelve interviews were conducted by telephone. A speaker phone was used for the telephone interviews to allow the interview to be taped. The interviews lasted from thirty to sixty minutes.

A semi-structured interview was used as the data gathering technique. The interview guide, attached in Appendix C, was adapted from the questionnaire used by Duncan (1989). Permission was received to adapt and utilize

Duncan (1989) designed the questions included within the data collection tool to guide the participants through the process of describing and analyzing the critical ethical elements of the situation. In Duncan's (1989) study the public health nurses were asked to recall an ethical dilemma and "describe retrospectively the circumstances, their role, the perceived conflict, options considered, actions taken, outcome, feelings, and supportive or inadequate resources" (p. 52). In this study public health nursing administrators were guided through a similar process, focussing specifically on an ethical problem they had experienced, in their administrative practice, in the past year.

**Data Analysis**

The content of the interviews was qualitatively analyzed to determine themes and to answer the research questions. Thematic content analysis was the data analysis technique utilized (Field & Morse, 1985). Content analysis is a method for "the objective, systematic, and quantitative description of communications and documentary evidence" (Roberts & Ogden Burke, 1989, p.344). Themes emerge from
the content analysis. The themes might be phrases, sentences, or paragraphs embodying ideas or making an assertion about the topic of study (Roberts & Ogden Burke, 1989). The themes identified are organized around the content of the messages conveyed as the participants responded to the interview questions. For example, in this study, some of the themes which emerged to describe the participants' responses to the ethical problem they experienced included stress, regret and uncertainty, and use of a decision-making approach.

In this study the following steps were taken:
1. The data were examined and themes identified. The themes related to the ethical problems encountered, the participants' responses to the ethical problem, and the variables which influenced the participant's experience;
2. A categorization system was developed for classifying and organizing the units of content (themes). These steps were consistent with those recommended in the literature (Polit & Hungler, 1989; Roberts & Ogden Burke, 1989).

**Rationale for Classification System**

Three categorization systems were developed to enable the classification of content in relation to the research questions. The rationale for the development of these category systems is discussed here.

The themes which emerged from analysis of the
participants' descriptions of the ethical problems they experienced were classified according to the sources of nursing obligations as identified by the CNA (1991) in the **Code of Ethics for Nursing**. These obligations are identified as "clients, nursing roles and responsibilities, society, and the nursing profession" (CNA, 1991, p.vii). Nurses experience ethical problems as they attempt to meet these obligations. It is therefore appropriate to utilize these obligations as the classification system for the participants' descriptions of the ethical problems they experienced.

The themes which emerged from analysis of the participants' responses to the ethical problems were classified according to how the participants acted, thought or felt about the ethical problem experienced. This classification system developed from the definition of the term "response" utilized in this study and previously discussed in Chapter One.

The variables influencing the experience were grouped into personal, professional, organizational, and system variables. This classification system naturally emerged as the data analysis proceeded.

**Reliability and Validity**

Findings are considered valid and reliable in
qualitative research when findings aid in knowing and understanding the phenomena as fully as possible and "consistently reveal meaningful and accurate truths about particular phenomena" (Leininger, 1985, p.69). The reliability and validity of the findings of this study were dependent on the ability of the subjects to answer the interview questions. As identified in the assumptions, it was anticipated that the subjects would be able to retrospectively recall and analyze ethical problems they had experienced, and would, in fact, answer the interview questions truthfully. The validity of this study was limited by the use of a convenience sample and was influenced by the researcher's ability to delimit the influence of her personal experience as a public health nursing administrator in the analysis of the data. The researcher utilized a technique known as bracketing (Oiler, 1982) to overcome this source of bias. To bracket, a researcher suspends or lays aside what is known about the experience being studied. This procedure facilitates "seeing" all the facets of the phenomenon. In this study, the process of bracketing was operationalized by the researcher engaging in periods of reflective thinking prior to and following each interview. Additionally, during the interviews the researcher clarified participants' responses in order to accurately reflect the participants' thoughts and feelings.
Miles and Huberman's (1984) strategies for examining the validity of qualitative measures were employed. These included checking for representativeness, checking for researcher efforts, triangulating, weighting the evidence, making contrasts/comparisons, checking the meaning of outliers or exceptions to the findings, ruling out spurious explanations, looking for negative evidence, and obtaining feedback from informants.

Protection of Human Rights

The protection of human rights in this study was assured in a number of ways. Authorization to conduct the study was obtained from the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. In addition, approval was obtained from the Ministry of Health of the Province of British Columbia.

Prospective subjects received a letter inviting their participation in the study. Potential participants were given an opportunity to ask questions and clarify any concerns about the study. Then, each participant signed a consent form. The written consent clearly indicated that the participant could withdraw from the study at any time, that participation or non-participation in the study would in no way affect the participant's employment status, and that the participant could refuse to answer any question.
Each participant received a copy of the consent form. Prior to every interview the researcher reaffirmed with each participant that each was still willing to participate in the study.

Confidentiality was ensured in a number of ways. All interview transcripts were coded and any identifying information was deleted from the transcripts. The researcher was the only one who had access to the master sheet on which the identities of the subjects were matched with the code numbers. This master sheet and the consent forms were stored separately from the interview transcripts and all research data (master sheet, consents, tapes and transcripts) were kept in a locked filing cabinet in the researcher's office. Interview tapes were erased and transcripts shredded following the acceptance of the researcher's thesis.

**Summary**

This chapter discussed the selection of participants, the processes involved in data collection and analysis, the reliability and validity of the study, as well as the ethical considerations of the study.
CHAPTER FOUR

Findings

The first section of this chapter contains demographic information about the participants. In the second section the themes which emerged as a result of analysis of the participants' responses are discussed. These themes are presented in relation to the study questions and, therefore, describe the ethical problems the participants experienced, their responses to these problems and the variables which influenced the participants' experience of the ethical problem.

Characteristics of Participants

Twenty public health nursing administrators participated in this study. All participants were women. The characteristics of the participants, including their years of general and public health nursing experience and levels of education are presented in Tables 1, 2, 3, and 4.
Table 1

**Years of Experience in Nursing, Public Health Nursing and Public Health Nursing Administration**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Public Health</th>
<th>PHN Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>10 - 36</td>
<td>4 - 30</td>
<td>.3 - 20</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>22</td>
<td>17</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 2

**Comparison of Years of Nursing Experience Between Public Health Nursing Administrators (PHN/A) and Public Health Nursing Assistant Administrators (PHN/AA)**

<table>
<thead>
<tr>
<th></th>
<th>PHN/A</th>
<th>PHN/AA</th>
<th>Public Health</th>
<th>PHN/A</th>
<th>PHN/AA</th>
<th>PHN Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range</strong></td>
<td>10 - 36</td>
<td>11 - 34</td>
<td>9 - 29</td>
<td>4 - 30</td>
<td>2 - 20</td>
<td>.3 - 12</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>22</td>
<td>22</td>
<td>19</td>
<td>16</td>
<td>12</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Table 3

**Educational Preparation of Participants**

<table>
<thead>
<tr>
<th></th>
<th>All (N=20)</th>
<th>PHN/A (N=10)</th>
<th>PHN/AA (N=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.S.N.</td>
<td>13 (65%)</td>
<td>4 (40%)</td>
<td>9 (90%)</td>
</tr>
<tr>
<td>Master's</td>
<td>7 (35%)</td>
<td>6 (60%)</td>
<td>1 (10%)</td>
</tr>
</tbody>
</table>
As noted in Table 3, the nursing education of the participants included thirteen with a baccalaureate degree in Nursing and seven with master's degrees in either Public Health, Public Administration, or Health Services Administration.

Table 4
Status of Position Held by Participants

<table>
<thead>
<tr>
<th></th>
<th>All (N=20)</th>
<th>PHN/A (N=10)</th>
<th>PHN/AA (N=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>13 (65%)</td>
<td>8 (80%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>Acting</td>
<td>7 (35%)</td>
<td>2 (20%)</td>
<td>5 (50%)</td>
</tr>
</tbody>
</table>

Differences between Public Health Nursing Administrators and Public Health Nursing Assistant Administrators

Ten of the participants were employed in the position of Public Health Nursing Administrator, and ten of the participants were employed in the position of Public Health Nursing Assistant Administrator. As noted in Tables 2, 3, and 4, differences existed between the characteristics of the participants holding the position of public health nursing administrator and those holding the position of public health nursing assistant administrator. The two groups had similar years of general nursing and public health nursing experience. However, the administrators had significantly more years experience in administration than
did the assistant administrators. The mean years of experience were 12 years for the administrators compared to 2.8 years for the assistant administrators.

Differences in educational preparation existed as well. Sixty percent (60%) of the administrators were prepared at the Master's level as compared to ten percent (10%) of the assistant administrators.

Differences in position status were also evident. Fifty percent (50%) of the assistant administrators held their position on an acting basis as compared to twenty percent (20%) of the administrators.

In general, the participants who held the position of public health nursing administrator had more administrative experience, a higher level of educational preparation, and were more likely to hold their position on a permanent basis than were the participants who held the position of public health nursing assistant administrator.

Ethical Problems Experienced

Seventeen of the twenty public health nursing administrators interviewed were able to describe an ethical problem they had experienced in the last year. One participant, although able to recall an ethical problem experienced in the last five years, was not able to recall one experienced in the last year. Two of the participants did not believe that they had experienced an ethical problem
in their administrative practice. The following presentation of the findings of this study are based on the responses of the seventeen public health nursing administrators who had experienced an ethical problem in the past year.

The themes which emerged from analysis of the participants' descriptions of the ethical problems they experienced are presented according to the sources of nursing obligation as identified by the CNA (1991). The sources of nursing obligations are clients, nursing roles and relationships, nursing ethics and society, and the nursing profession.

**Clients**

Four participants (23.5%) described ethical problems related to clients. Specifically, problems related to respect for needs and values of clients, respect for client choice, and confidentiality were identified.

**Respect for needs and values of clients.**

One participant described a problem experienced when staffing a Sexually Transmitted Disease Clinic and a Family Planning Clinic:

Some of the nurses have a real problem working in those clinics. I can appreciate that but my issue is that ethically in practice, in community health, a nurse is going to have to accept that she is going to be up against issues that run contrary to how she would run her own life. Ethically, we are not to judge our clients but merely to provide information and support in decision making.

Another participant identified a conflict between
personal beliefs and Ministry policy which she had experienced during an outbreak of a communicable disease. A prophylactic vaccine was made available to certain risk groups; however, parents of children outside the specified risk groups were demanding vaccine for their children as well. She stated:

My ethical problem was that many confusing statements had been made by the Ministry of Health, my problem was in dealing with the parents. I could sympathize with their concerns and wants, but I was bound by Ministry policy.

Respect for client choice.

One participant identified an ethical problem experienced when a community agency was widely offering inaccurate information related to teen sexuality and attempting to limit teens' access to information:

It has to do with the whole area of personal choice for people...we have had to examine what our role is in terms of family planning and sexuality. Our role is not to make decisions for people, it is to give balanced information. The issue is autonomy for the client.

Confidentiality.

One participant described an ethical problem experienced as she provided support to a staff nurse who was working with a complex client problem. The public health nurse was working with the family on an identified problem (grief) and, at the same time, the nurse was being asked by Crown Counsel, the police, and Ministry of Social Services staff to provide information about the family. The administrator expressed her concerns this way:
You are put in a situation where on the one hand you know that information is confidential and on the other hand, at times, you must give confidential information. So it's a matter of what you do and what you don't do and how, with this sort of over-riding umbrella, your care is affected.

The category of ethical problems related to the nursing obligations to clients was the second largest category of responses. Three of the four responses in this category were given by public health nursing assistant administrators.

**Nursing Roles and Relationships**

This was the largest response category with twelve (70.5%) participants identifying problems in this area. Participants identified ethical problems related to protecting clients from incompetence, conditions of employment, and job action.

**Protecting clients from incompetence.**

"Nurses are obliged to take steps to ensure that the client receives competent and ethical care" (CNA, 1991, p. 15). Participants described four ethical problems related to staff incompetence and one situation in which the participant perceived that a family was receiving unjust treatment by Ministry of Social Services staff.

Three participants described situations in which they observed new and long term employees who were unsafe in their immunization practices. The participants stated:

I was routinely observing a nurse who had something like thirty plus years experience, expecting that it would be just a kind of routine thing. I was just
extremely taken a back when I went into clinic because her practice was terrible. She gave misinformation, she missed some of the basic things like proper screening before immunizing. I was just aghast, I couldn't imagine how anyone could practice that long and do so poorly in something as basic as immunization clinic.

It was a nurse who, during her probation, was judged by myself and my supervisor to be unsafe to practice, specifically in her administration of immunizations.

We had an incident where a nurse really didn't believe in immunization, which makes it impossible to work in community health. She didn't give clients all the information so that they could give informed consent.

Two of these situations occurred shortly after the participants had assumed the position of public health nursing assistant administrator.

Another participant described a situation in which a staff nurse was dealing with so much personal stress that her ability to practice safely was questioned by the administrator:

I had a staff member whose practice was fine and then home life stress caused extended stress and extended problems. This caused me concern with safety to practice issues.

One participant identified a situation in which she perceived another professional's (Social Worker) treatment of a family as unjust and unethical. As she stated:

It seems what they (Ministry of Social Services) are doing is such a judgement call...The conflict that exists is what a healthy family situation is versus what I see Social Services doing. It's also what is the norm for other families versus what we're seeing in this situation.

All five responses in this category were given by
public health nursing assistant administrators.

**Conditions of employment.**

Conditions of employment should contribute in a positive way to client care and the professional satisfaction of nurses. Six participants gave responses in this category.

One participant described an ethical problem related to allocation of resources. The manager was faced with making a decision about a particular client service. She expressed her concerns as follows:

> We didn't have the staff and the resources to offer all the other services in the other programs. We felt the type of service we were offering was less than satisfactory, that really it was difficult to keep the staff updated with current information. We didn't feel that the service that we were giving to clients was a superior service so we had to make a decision. It certainly wasn't one that we took very lightly. Really what we needed to do was expand (this service) but when we saw that other service areas were dropping we were caught there. All of them provide services to clients, but which one were we going to continue giving. Giving at a level expected of a professional.

Another administrator described the ethical problem she experienced in trying to balance the sometimes conflicting needs of programs and service provision versus the needs of staff. She said:

> The problem between servicing the public, prioritizing the issues that have to be dealt with, within the resources we have, and yet still allowing the nurses to do those things in their work which makes them feel good and gives them the rewards they need...Of course we (nursing administrators) are the meat in the sandwich. We're getting the message from up above saying "thou shall create this community development, live within your FTE resources, do the whole bit", and you have this other group down there saying but we need
to provide service, we can see the problems with the people we're dealing with.

Two participants described situations involving a conflict of values with the Medical Health Officer (MHO)/Director related to the role and value of public health nurses. The administrators said:

Setting public health nursing priorities with the knowledge of what you believe Public Health Nursing should be, or preventive programs should offer, versus the more limited view of XX (MHO/Director). He sees public health nursing as primarily communicable disease follow-up and immunization versus the preventive approach that addresses both health prevention and promotion issues.

The conflict for me is the lack of appreciation and valuing of Public Health Nursing and the different value set between the MHO and I. It becomes a problem when there is a serious impact on our planning or in how effective I am in managing the program. Sometimes I feel as if I'm being sabotaged from the side.

One participant identified an ethical problem she experienced when she and the rest of the Public Health Nursing staff in the office perceived that a support staff member was being unfairly treated. She stated:

The situation contradicts what I believe in, my values, my work ethic, and my sense of fairness. The most difficult thing about this has been the amount of time that's been spent on it, seeing someone being very, very hurt, and seeing the impact on the staff, how it has started to reflect on the nursing staff morale.

Another participant described an ethical problem she experienced when a letter of reference was requested for a staff member who the participant was "having a lot of difficulty with" and that the participant "really didn't want to keep on staff". The participant's response
illustrated the conflict between her obligations to truth-telling and her obligations to the other staff members. She stated:

The nurse was causing an awful lot of difficulty with other staff...other staff were requesting transfers out of that office on a regular basis because they couldn't deal with this one person...We had tried everything over the years...I found that (the request for a letter of reference) a real ethical dilemma. You know you have to be honest, it would be unfair to the other agency not to be...Yet, in another sense, she may well be good at that job...I was thinking I can't think of any other solution...I thought, if I do this (write a reference letter) it will be a good solution for that office. Who was my responsibility most to?

Job action.

One participant discussed the conflicting loyalties and obligations experienced being a manager and a member of a union. She described her problem as follows:

You have to function outside the union in a big part of the job that you do as a PHN Administrator. If you are making decisions regarding management of the union contract or if you are undertaking disciplinary action, then you are functioning as a manager, not as a union member. When it comes to how the staff perceive you or how the union perceives you, especially in a strike situation, then you are a union member. The conflict is that as a PHN you should have some loyalties to the union because they do the negotiating for you in terms of your salary, and benefits, and all the other things that are within the union contract. But the fact is that there is very little loyalty there. They don't do a whole lot for me in terms of my role in management. In fact they undermine that role in a lot of situations.

Nursing ethics and society

Nurses have ethical obligations to advocate for the interests of clients, the community and society. One participant gave a response in this category.
Advocacy of the interests of clients/community.

One participant discussed the ethical problem she experienced when the local hospital proposed an early postpartum discharge program. It would have been reasonable and acceptable, within the health unit mandate, for the administrator to have stated that she did not have the resources to participate in the local initiative. However, she did not feel this was in the best interests of the community. As she stated:

I thought to treat it as if that's the hospital's problem was not good enough because I felt it really was a women's issue and it was a nursing issue.

Summary

The participants reported ethical problems related to clients, nursing roles and relationships, and nursing ethics and society. The largest response category was nursing roles and relationships, with 71% of the identified ethical problems in this category. No ethical problems related to the nursing profession, as a source of nursing obligations, were identified.

Response to Ethical Problems

The themes which developed from analysis of the participants' responses to the ethical problems they experienced are discussed here. As discussed in Chapter One, the term "response" is defined to mean the ways in which public health nurse administrators act, think, and
feel about the ethical problem experienced. The categories of responses discussed in this section are not mutually exclusive.

**Stress**

More than half of public health nursing administrators (52%) reported feeling a significant amount of stress while experiencing the ethical problem. The following excerpts are illustrative:

The situation was very stressful. Looking back, I'm not sure how I got through it.

It's stressful on a personal level to be critical of someone's practice.

I did a lot of thinking and it caused me stress, so I had to deal with my own stress.

I thought how can this be allowed to happen and I had a sick feeling inside of myself.

All of the administrators who identified an issue of staff incompetency reported feelings of stress associated with the role conflict they experienced when ensuring client safety and, at the same time, supporting and advocating for staff members. As the participants stated:

The most difficult thing was thinking of the personal stress that it would cause the nurse. I knew it would, but I had to draw these things to her attention.

It's very stressful...I think it's the concern over how you are going to affect them personally, as opposed to you know you have to draw this to their attention, you can't not do that, it wouldn't be ethical not to because then you're putting the clients at risk.

You have to balance it...the safety issues for the clients versus the staff saying don't cut my lifeline.

Another component of the stress the participants
experienced was related to the amount of work and personal
time the experience of the ethical problem consumed. One
participant stated "I spent a lot of time thinking about
it...I spent a lot of time at night trying to decide what to
do". Another participant said "I thought about nothing
else for two days".

Use of a decision-making approach.

All the participants attempted to resolve their ethical
problems by utilizing a rational decision-making approach.
One participant utilized an ethical decision-making process.

In response to a situation involving concerns about a
staff nurse's immunization practice one participant took the
following steps:

The immunization errors were discussed with the staff
member, plans were made to improve her practice...I
documented it and consulted my immediate supervisor and
I talked to our personnel officer as well.

When faced with a decision about withdrawing a client
service a participant reported the following process:

We (management team) had lots of discussions...this went
on for about 6 months as we explored alternatives... we
considered staffing levels and program activities...we
discussed it with staff...we made the decision to cut
this program because it was self contained, we had
problems updating staff...the clients often received
conflicting or inaccurate information...there was a
superior service available to our clients nearby...we
weren't just removing a service and not offering an
alternative... we are continuing to monitor the
situation.

As previously stated, only one participant reported
utilizing an ethical decision-making process. Ethical
decision-making is intended to apply various skills of
ethical analysis and reasoning in an attempt to reach a well-grounded solution to an ethical problem (Benjamin & Curtis, 1986). The following excerpts illustrate the process:

I could appreciate their (some staff members) moral difficulty...I had to ensure that proper, responsive, and adequate services are delivered to the client group.

My issue was do you allow nurses who feel uncomfortable in certain situations, because of their aversion with peoples lifestyles to avoid working with these groups. Is that okay? The answer is no...ethically we're not here to judge our clients but to provide information and support in decision-making.

The conflict for me was to make the staff happy or to make sure that the client group was okay, and for me, the client group had to come first.

We talked about it in an open meeting...I considered allowing staff to opt out of those clinics...We set up support systems for existing staff...We made our expectations clear in hiring new staff.

An administrator has to be an ethical model, we have to take ethical stands that may not always be popular, but if we are standing on good ground in terms of our ethics and making decisions people understand...it's not always easy but it is part of being a professional nurse.

We are here to provide a service to the public, that's our mandate.

This is about our client's right to choice...our role is to provide information so they can make a choice...not to judge whether the choice is right or wrong.

These steps are consistent with ethical decision-making (Ericksen, 1990).

Values clarification.

Values clarification is the systematic process of
choosing, prizing, and acting on one's own values (Steele & Harmon, 1983). Two responses showed evidence of a values clarification process:

We spent time as a working group clarifying values related to the issue. We now have a plan of action that we feel comfortable with. I think that's important, for the nurses to feel comfortable in what they are doing.

I could understand the discomfort some of the staff were having in this situation. We explored the issue in an open meeting. I could understand their moral difficulty, but we are not asking the staff to make the decision for the client, and we are not asking that they approve or disapprove of the client's lifestyle...But what we are asking them to do is to provide information for people to make decisions and to support them in what decisions they make...that is part of being a professional nurse.

**Regret and uncertainty.**

Five administrators expressed feelings of regret or uncertainty about the decisions they had made, as the following excerpts illustrated:

There are lots of times when I still think that I made the wrong decision...I guess that is part of the thing with ethical decisions is that even when you make the decision you think is the right one ethically, you still may have a lot of regrets, and I do.

The most difficult thing was coming to the realization that I would have to give up what I really would have liked to have done. There are lots of times when I still think I made the wrong decision.

What if she said "No"? What would I have done? I don't know what I would have done. To this day I think "what if".

The difficult thing is...seeing the impact on the staff. I don't want to let the staff down.

You ask yourself, "What else could I have done"?
Failure to act.

Two of the responses indicated that although the initial problem was resolved to a certain end point, ethical concerns persisted and these were not resolved. One administrator, who had to deal with a staff members' incompetency, noted:

I do think that any staff member who had been there for any length of time and had worked with her was aware that she was not a very competent person.

However, staff colleagues had not "whistle-blown". The failure of staff members to fulfill their professional obligation was not dealt with. Another administrator stated:

This happened just over a year ago. The file has just sat in my drawer. I know she isn't practicing nursing...I haven't had time to think it through...What do I do about this now? Am I obligated to report this to the professional organization?

Use of personal resources.

Several participants identified that they utilized personal resources, such as personal experience and spiritual beliefs, in dealing with the ethical problem. Previous personal experience was utilized by 47% of the participants. One participant stated that she would have found more personal experience a helpful resource. One participant relied upon her spiritual beliefs and prayer as a source of support.

Use of external resources.

All participants sought out resources to assist them in
resolving the ethical problem. The most commonly used resource was public health nursing administrative colleagues (76%). Staff members (29%) were also utilized by several participants. Participants also identified the Public Health Nursing Central Office staff, the Medical Health Officer, the Health Unit management team, spouses, management colleagues outside of health care, friends, and classmates as resource persons utilized. Ministry of Health policy, the Registered Nurses Association of B.C., and the Code of Ethics were also identified.

It is also interesting to note that six participants identified the resources of the Medical Health Officer and the Public Health Nursing Central Office staff as not helpful or not approached because it was expected that their input would be not helpful. In reference to the Medical Health Officer, one participant stated:

In my experience most of the medical health officers I've dealt with wouldn't be helpful in this situation. Their attitude would be, this is the practice, just bloody well get on with it. And that's not very helpful.

In reference to the Public Health Nursing Central Office staff a participant said:

It was an in-house problem and it wouldn't have occurred to me to use the consultants in Victoria. We haven't had that kind of relationship with them for so long that it wouldn't even enter my head. And also I think ... they are not up on the practice and it is therefore difficult for them to relate.

Participants were also able to identify external resources they wished they had available to them. These
resources included access to a medical ethicist, an objective mediator, supportive policy, and material resources such as inservice training for the staff.

Summary

The participants responded in a variety of ways to the ethical problems they experienced. These responses included feelings of stress, regret and uncertainty; utilization of a decision-making approach; values clarification; the use of personal and external resources; and failure to take action to completely resolve the ethical problem.

Variables Influencing the Experience

A number of themes emerged related to the variables which influenced the public health nursing administrators' experience of the problem. These themes were grouped into personal, professional, organizational, and system variables.

Personal variables

The personal variables identified included the presence or absence of previous administrative experience, personal experience, and the amount and type of support available.

Previous administrative experience.

Participants who lacked administrative experience reported feelings of acute stress associated with the experience. The following excerpts illustrate:

It was within a very few months of assuming the acting position...I was basically thrown into a situation that
I had never had to deal with before...Looking back I'm not sure how I got through it. It was a very acute stressful situation.

I'd been in the position about four months...I was getting used to a new job, in a new health unit, and then these problems came up...it was very stressful.

The participants also identified that a significant amount of their time was taken up with the ethical problem and the process of trying to resolve it. As the participants stated:

I spent a lot of time thinking about it...I spent a lot of time at night trying to decide what to do.

I thought about nothing else for two days.

**Personal experience.**

As previously discussed, several participants (47%) utilized personal experience as a resource to assist in dealing with the ethical problem. One participant expressed the belief that, perhaps, with more life experience the resolution of ethical problems would be easier. Another participant was aware that her experiences as an adolescent were influencing her experience of the current ethical problem of lack of respect for autonomy. She stated:

The most difficult thing for me was that I had come from the same sort of background myself. I had to face, as a young adult, the same kind of pressure that I now see being put on these young girls. Other people's opinions and decisions being put on me instead of allowing me to make my own decisions.

**Support.**

Six of the participants (35%) stated that they felt supported by the resource people they had sought out. For
this group the support contributed, in a positive way, to the experience of the ethical problem. One participant stated "I'm feeling really fortunate that I've had support by the people I've been able to seek out. This has helped my to hang in and resolve this to the very best of my ability."

The remaining participants commented that, despite the number of resources utilized, they either had no support or that the support available wasn't helpful. As participants stated:

I'm not sure where that support would come from, I think that it's something that I have had to work through myself.

My peers were as supportive as much as they could be, but the decisions and actions were mine to take. The support was there but it wasn't all that practical. I just had to do it myself.

No, I didn't feel supported. I was it, and in my experience, in public health nursing, as the administrator, that's the way it is.

For one participant, who was faced with a problem of staff incompetency, an overt lack of support negatively influenced the experience. She commented:

One of the other staff members said something to me to the effect that it had been noticed that XX had gone off immediately after I had been supervising her and they were wondering if it had anything to do with that.

Professional practice variables

The professional practice variables relate to the degree to which staff and administrative nurses fulfilled their professional practice obligations. This variable was
particularly related to situations of staff incompetency. As previously discussed, one participant identified a situation in which she, as a new public health nursing assistant administrator, became aware of an incompetent staff nurse, who had been employed for many years. The failure of previous nurse administrators and staff colleagues to address the safety to practice issues was a negative contributing factor. The participant stated:

I had gone back to her previous evaluation...it was a fairly reasonable evaluation...it was probably over two or three years old...there was no mention of basic incompetence and the unsafe practice I'd observed...I think that any staff member who had been there for any length of time was aware that she was not a very competent person...They were all aware of her incompetency.

In fact, after the participant had taken actions to ensure client safety, staff nurses did not support her. As she described:

After this particular nurse had been off for a couple of months one of the other staff members said something to the effect that it had been noticed that XX had gone off immediately after I'd been "supervising" her and they were wondering if it had anything to do with that.

Nurses are professionally and ethically bound to support nurses who attempt to protect clients from harm. The failure of these nurses to fulfill their obligations was a negative contributing factor.

Organizational variables

The organizational variables include acting positions, staffing levels, the role of Central Office, the nature of the relationship between the administrator and the medical
health officer, resources, and policies.

**Acting positions.**

As previously discussed (35%) of the participants were in acting positions. Participants who were in administrative positions on an acting basis found this to have a negative impact on their experience. The negative impact was, in part, related to the fact that those administrators in acting positions often had little administrative experience. The negative aspects of the situations were exacerbated by the fact that there were no organizational structures in place to support the participants who held acting positions. Two participants reported that the ethical problem they experienced occurred when they were acting as Assistant Administrators and then due to illness or another unexpected event, had to act as the Administrator. They reported they had no support and no orientation. One of the participants stated:

> In an acting position you are not quite sure because you never have dealt with it before. As an assistant administrator you never have the final authority. Suddenly, without an orientation and with no support, I was expected to make these decisions. You have to find out by error and by that time your acting position is over.

**Staffing levels.**

A lack of staff was identified by four participants as negatively influencing the experience of the problem. For two participants, a lack of nursing administration staff related to a lack of support. Two other participants, who
were dealing with issues of staff incompetency, identified the increasing caseloads of their staff as a major contributing factor.

**Role of Central Office.**

As previously discussed, several participants identified the role of the Public Health Nursing Central Office staff as an influencing factor. The supportive and consultive expertise provided by the Public Health Nursing Central Office staff was identified by two participants as a positive influence. Several participants did not look to the Central Office for assistance as they anticipated the input would not be helpful. The roles of Public Health Nursing Central Office staff have changed significantly in recent years from that of consultants to that of program managers. In the view of several participants the current role did not enable the Central Office staff to provide appropriate and helpful consultation on the ethical problems the field staff experience.

**Nature of relationship between the administrator and the medical health officer.**

One participant identified consultation with the medical health officer as a helpful part of the process of dealing with the ethical problem. Two participants identified the nature of their relationship with the medical health officer as a negative influence on their experience. In these situations the participants perceived that the
medical health officers did not view or value the role of public health nursing in the same way that the participants did. For these participants this value conflict precipitated the ethical problem. For others, this inherent value conflict meant that the participants did not consider the medical health officer, who is the public health nursing administrator's supervisor, as a resource in resolving the ethical problem experienced.

**Resources.**

Generally, the increased availability of resources had a positive effect on the experience of the problem. This has been previously discussed. One participant commented that the lack of ongoing staff education opportunities contributed to the development of the ethical problem. She stated:

> I think it presents a dilemma too, because once you set priorities that require skills that all staff don't automatically have then you also have to commit education and training to help them develop those skills. And that is something that had been really difficult in our system.

The lack of support and absence of orientation for participants holding acting positions also relates to resources and has previously been discussed.

**Policies.**

Both the absence and presence of policies had a negative impact on the administrators' experience of the ethical problem. Participants identified clear policy direction as a resource they wished they had available to
them. For one participant, an existing personnel policy contributed significantly to the negative experience of the ethical problem. The participant was dealing with an issue of staff incompetency. The staff member had gone off on stress leave, and in the mean time, the decision had been made to terminate the employee. According to personnel policy, the administrator was not allowed to advise the employee of the decision to terminate her employment until the employee had advised the employer of her intention to resign or return to work. As the administrator stated:

Wanting what was best for her as an employee and a person, not being able to share that information with her...I just felt that either way it wasn't being fair to her...if she was continuing on thinking that she was coming back. Not being able to say anything to her on that sick leave at all was really difficult.

System variables

The system variables related to factors at the health and human service system level. They included the availability of alternate client services within communities and communication systems with allied agencies such as the Ministry of Social Services.

Availability of alternate client services.

For one participant, the availability of alternate client services was a positive contributing factor to the resolution of the resource allocation problem experienced. Conversely, the lack of available alternate client services limited the options one participant felt she had in
resolving the ethical problem.

Communication systems with allied agencies.

For one participant, the communication systems between the Health Unit and the Ministry of Social Services were problematic. The participant perceived that a family was being treated unfairly by a social worker but was unable to access information from the Ministry of Social Services which might have clarified the situation.

Summary

In this chapter the research findings have been presented. Demographic information about the participants and the themes which emerged as a result of content analysis of the participants' responses have been presented. The participants in this study reported ethical problems related to clients, nursing roles and relationships, and nursing ethics and society. The participants' responses to the ethical problems experienced included feelings of stress, regret and uncertainty; utilization of a decision-making approach; values clarification; the use of personal and external resources; and the failure to take action to completely resolve the ethical problem. The variables which influenced the participants' experience of the ethical problem included personal, professional, organizational, and system variables.
CHAPTER FIVE

Discussion of the Findings

The findings of this study will be discussed in accordance to the ethical problems experienced, the participants' responses to these problems, and the variables which influenced the participants' experience of the problem. 

Ethical Problems Experienced

The ethical problems the participants experienced were categorized according to the sources of nursing obligations, as identified by the CNA (1991) in the Code of Ethics for Nursing. According to the CNA (1991), the sources of nursing obligations included clients, nursing roles and responsibilities, nursing ethics and society, and the nursing profession. In this study, the majority of participant responses (70.5%) were classified in the category of nursing roles and responsibilities. The ethical problems identified related to protecting clients from incompetence, conditions of employment, and job action. The second highest response category was clients (23.5%). In this category the ethical problems identified related to respect for needs and values of clients, respect for client
choice, and confidentiality. Only one response (6%) could be classified in the nursing ethics and society category. This was an ethical problem related to advocacy of the interests of clients and community. No responses related to the nursing profession were identified. These findings were consistent with studies reported in the literature (Arsokar, 1989; Duncan, 1989, Sietsema & Spradley, 1987; Youell, 1984) wherein the ethical problems identified focused primarily on the individual client and advocacy for that individual; ethical conflicts related to health team relationships; the allocation of and rationing of resources; staff competency (both nurses and physician); and patient rights (such as informed consent and the right to refuse treatment).

The values and obligations presented in the Code of Ethics for Nursing (CNA, 1991) were presented by topic and not in order of importance. Therefore, it could be expected that the responses in this study would have fallen into all four categories. However, this was not the case. It is interesting to note that, in this study, the ethical problems described by nursing administrators were primarily (94%) classified in the response categories of clients and nursing roles and responsibilities. The findings of this study suggested that problems exist in public health nursing administration, as in other areas of nursing, related to conflicting loyalties and lack of autonomy.

Several authors have questioned the freedom of nurses to
practice nursing within bureaucratic settings, which threaten their professional and personal well-being (Christensen, 1988). The findings of this study supported Yarling and McElmurry's (1986) contention that nurses are not free moral agents. Yarling and McElmurry asserted that the fundamental moral problem of nursing is a consequence of the structure and policies of the social institution in which nursing is practiced. This premise is supported by the work of Lamb (1985) who found that nurses perceived the negative effects of the multiple and conflicting loyalties existing within various nursing practice settings and the limitations on nurses' abilities to uphold the value of patient autonomy.

Ethical autonomy, or the freedom to choose or to independently endorse a given course of action, is basic to the practice of professional nursing (Benjamin & Curtis, 1986). Professional competence includes both practical and ethical dimensions. Thus nurses cannot be totally competent, or autonomous, until they are able to be more ethical (Jameton, 1984). The results of this study indicated that public health nursing administrators experience problems with lack of autonomy, as do nurses in other practice settings.

**Ethical Themes**

The ethical problems identified in this study involved the ethical principles of beneficence, autonomy, and justice
Beneficence.

According to Frankena (1973) the principle of beneficence says that "one ought not to inflict evil or harm, one ought to prevent evil or harm, one ought to remove evil, one ought to do or promote good" (p. 47). One participant described a situation wherein a vaccine was available to prevent illness but, due to Ministry policy, the vaccine was only available to specific groups who were deemed "at risk". In this situation the administrator was concerned that she was not fulfilling her obligation to prevent harm and was not able to universally "promote good". The ethical problem related to confidentiality also involved the principle of beneficence. The administrator's duty to prevent harm (through possible child abuse by parent) was in conflict with her duty to promote or do good (through continued interventions with family). The situations related to protecting clients from incompetence also involved the principle of beneficence.

Autonomy.

The principle of autonomy is based on the idea that individuals are self-directing and therefore capable of choosing and acting upon decisions they themselves have decided on (Fry, 1983). To respect persons as autonomous individuals is to acknowledge their personal rights to make choices and act according to individual determinations. One administrator described a situation in which some staff
members expressed concern about working with particular client groups. The administrator believed that the nurses' obligation was to provide information and support the clients in whatever choice they made for themselves. Another participant described a situation in which a community group was offering inaccurate information related to teen sexuality and attempting to limit teens' access to information. These actions violated the principle of autonomy and, therefore, these actions were unacceptable to the administrator.

Other examples involving the principle of autonomy are found in the situations involving a conflict of values with the Medical Health Officer related to the roles and valuing of public health nurses. In these situations the rights of self determination of nurses and nursing was being interfered with by another discipline. The ethical problem related to the administrator being part of a union also involved the principle of autonomy.

Justice.

The administrators also described situations in which the principle of justice was involved. Situations related to conditions of employment, in which the administrators were attempting to decide who should receive which services, for which reasons, involved the principle of distributive justice. Distributive justice focuses on the allocation of goods and services (Jameton, 1984). From a utilitarian
perspective, the principle of distributive justice directs that an action is right if it leads to the greatest possible balance of good consequences or to the least possible balance of bad consequences for all persons involved with the action, and that which maximizes the good determines what is right to do.

The principle of justice was involved in the situation involving a letter of reference for a troublesome employee. In this situation, the administrator struggled with the conflict between the good consequences for her staff if this employee left versus the unfairness to the agency requesting the reference letter.

Another example of the principle of justice was illustrated by the situation in which the administrator and the rest of the public health nursing staff in the office perceived that a support staff member was unfairly treated. Rawls (1971) definition of justice as fairness if most appropriate here.

The ethical problem related to advocacy of the interests of clients and community involved elements of beneficence, autonomy, and justice. The principle of beneficence was demonstrated by the administrator's concern about doing good (for postpartum families) and avoiding harm (caused by early hospital discharge without adequate community service). Autonomy was demonstrated by the administrator's desire to ensure that families had choices
in type of postpartum experience they had (versus this being dictated by a bed utilization committee). Finally, justice was involved because the administrator was concerned with the equitable distribution of health care resources in the community.

No Ethical Problem Identified

Three of the twenty public health nursing administrators, interviewed for this study, could not identify an ethical problem they had experienced in the past year. As previously discussed, one participant was able to identify an ethical problem experienced in the past five years, but was unable to identify one experienced in the past year. Two participants did not believe they had experienced an ethical problem in their public health nursing administrative practice. The response of one participant bears further discussion. This administrator, after thoughtful consideration, stated that she experienced problems that had an ethical component, but that the economic or legal components of these problems were of primary importance. The participant also described the problems as amenable to a rational problem solving process. This participant acknowledged that although some might call these problems ethical problems, in her mind, they were not.

The findings of this study are similar to the findings of other studies reported in the literature (Davis, 1989; Duncan, 1989). Davis (1989) reported that discrepancies
existed between participants definition and understanding of the concept of ethical dilemma. Duncan (1989) found that five of the thirty participants in her study reported experiencing no ethical problems.

In both this study and Duncan's (1989) study, interesting similarities existed in the demographic characteristics of the participants who reported experiencing no ethical problems. In this study, the three participants who reported experiencing no ethical problem in the past year had more years of public health nursing experience than did the total sample (mean = 20.6 versus 17) and significantly more years of public health nursing administrative experience than did the total sample (mean = 17 versus 7). Duncan also found that the participants who reported experiencing no ethical problems had slightly more years of public health nursing experience than the total sample of her study (mean = 11.5 years versus 9.8 years). Duncan postulated that perhaps nurses who work in a setting for many years become desensitized to the experience of ethical problems in their nursing practice. Duncan concluded that further study was warranted to identify those factors which may influence public health nurses' ability or tendency to perceive the ethical dilemmas in their practice. The findings of this study also suggest that further research in this area is needed.
Public Health Nursing Administrator's Responses to Ethical Problems

As discussed in Chapter Four, the Public Health Nursing Administrators' responses to the ethical problems they experienced were categorized according to how they acted, thought, or felt about the experience. The responses included stress, utilization of a decision making framework, values clarification, regret and uncertainty, failure to act, use of personal resources, and use of external resources.

Stress

In this study, all the participants reported feelings of stress as they experienced the ethical problem. This reaction is similar to the findings reported in other studies. Several of the participants reported feelings of moral distress. Fenton (1988) and Wilkinson (1986) have reported this response to moral conflict. Moral distress is the disturbing emotional response which arises when one is required to act in a manner which violates personal beliefs and values about right and wrong (Wilkinson, 1986).

As discussed in Chapter Four, the stress reported by those participants who were dealing with issues of staff incompetency was related to the conflict they felt between their conflicting obligations to clients and their desire to support and advocate for staff. Lamb (1985) also identified
this problem of multiple and conflicting loyalties. According to the CNA (1991) "nurse managers bear special ethical responsibilities that flow from a concern for present and future clients" (p. 11). When faced with conflicting loyalties between clients and staff, the nurse administrators in this study decided that their obligation to the client had higher priority.

Utilization of a Decision-Making Framework

Although all participants utilized a decision making framework in dealing with the ethical problem, only one participant in this study reported a response, to the ethical problem they experienced, which could be classified as an ethical decision making process. These findings are consistent with the findings of Youell (1986) who reported that the approaches used by nursing administrators to resolve ethical problems revealed a lack of systematic referral to ethical principles. All participants in this study attempted to resolve their ethical problem by utilizing a rational decision-making approach. These findings did not support the findings of Sietsema and Spradley (1987) who found that nurse administrators based the resolution of the ethical problems they faced on their own and others' personal values and beliefs. Nor were Davis' (1989) findings nurses primarily utilized religion as their moral guide in responding to ethical problems supported by the findings of this study.
The educational preparation of the participants of this study may be a factor which influenced the ways in which the nursing administrators resolved the ethical problems they experienced. As discussed in the previous chapter, 65% of the participants had a baccalaureate degree in nursing. The majority of participants had completed this degree more than ten years ago when nursing ethics may not have had a great deal of emphasis in their nursing curriculum. The remaining participants (35%) had completed master's degrees, however, none of these degrees were earned in nursing. Instead, these participants had chosen to complete master's degrees in Public Health, Public Administration, or Health Services Administration. Therefore, although ethics may have been part of the curriculum, nursing ethics was not.

According to Fry (1986), most nursing executives have learned about values and their fundamental role in ethical decision making through business management courses, their own insight, and socialization into the nursing management role. As Fry (1986) pointed out, these modes of learning have not been supported by research on the types of moral decisions made by nurses executives and their preparation for these decisions.

The decision-making approach utilized by participants in this study is similar to the model advocated by Sullivan and Brown (1991b) for administrative decision-making in ethical issues. This type of decision making for ethical
issues in nursing administration warrants further study.

Regret and Uncertainty

Two of the participants in this study expressed regret with the decisions they had made in order to resolve the ethical problem. Both participants felt they made the morally correct decision; however, there was a price to pay for making the decision that they did for both administrators. This is not an unexpected response, as ethical 'oughts' are not always congruent with personal 'wants'.

Three of the participants stated that they felt uncertain about the decisions they had made. Possibly, this was related to the fact that they had not utilized an ethical decision making approach in resolving the ethical problem. The use of an ethical decision making approach "enables the nurse to make a decision that is morally defensible and can be communicated in a rational manner" (Ericksen, 1990, p. 396).

Failure to Act

In this study, two participants' responses indicated that although the initial problem was resolved to a certain point, ethical concerns persisted which were not resolved. This lack of action could be related to a lack of awareness of, or concern about, the ethical issues remaining. Other possible explanations are that the administrators were not able to develop any strategies to resolve the problem, or
perhaps, as one participant stated, there was no time to
deal with the problem.

Utilization of Personal and External Resources

Participants in this study sought out a variety of
personal and external resources to help them with the
ethical problems they faced. The types of resources
utilized are similar to those reported in other studies
(Aroskar, 1989; Duncan, 1989; Sietsema & Spradley, 1987;
Youell, 1984). However, the two resources which are most
frequently mentioned in the literature, namely the code of
ethics and ethics committees, were rarely or never mentioned
by the participants in this study.

Despite the number and variety of resources utilized,
most participants stated that they did not feel supported.
Similar findings were reported by Aroskar (1989) and Duncan
(1989). Sietsema and Spradley (1987), in their study of
ethics and administrative decision making, reported that
71.2% of the respondents judged the resources available as
sufficient. Unfortunately the term sufficient was not
defined, nor was the concept of support considered.

Youell (1984) found that the hospital nursing
executives she studied identified the medical staff as one
of the primary resources utilized. In this study, the
medical health officer (MHO) was not utilized frequently.
In fact, several participants responded that they did not
consider using the medical health officer as a resource
because they perceived that this would not be useful. One participant's comment was particularly interesting. She stated that the anticipated response of the MHO was "This is the practice, just bloody well get on with it". The variance in approach between the female nursing administrator and the MHO, who is generally male, may be explained by the work of Gilligan (1987). Gilligan (1987) asserted that the female 'ethic of caring' is different that the predominantly male 'ethic of justice'.

Variables Influencing the Experience

A number of variables which influenced the public health nursing administrators' experience of the ethical problem were identified in the previous chapter. These variables included personal, professional, organizational, and system factors.

Personal Variables

This study found that previous administrative experience was identified by participants as having a positive effect on their experience of the ethical problem. The studies by Sietsema and Spradley (1987) and Youell (1984) did not examine influencing variables. Duncan (1989) reported that experience and professional competence were viewed by participants as positively influencing their experience.

The presence of support was identified as a variable
which positively influenced the participants' experience of the ethical problem, however, for most participants this support did not exist. Duncan (1989) reported similar findings. The nursing administrators included in Duncan's sample identified their need for support. The support these administrators found happened on an informal basis and, as in this study, no formal mechanisms existed to provide this needed support to administrators who were often geographically isolated from their peers.

**Professional Practice Variable**

The professional practice variables related to the degree to which staff and administrative nurses fulfilled their professional practice obligations. As discussed in the previous chapter, one participant found herself, as a new administrator, inheriting a long term problem of staff incompetency. The CNA (1991) Code of Ethics was clear and specific about the obligations of nurses to protect clients from incompetence. The Code also acknowledged that the nurse who attempts to protect clients or colleagues threatened by incompetent or unethical conduct may be placed in a difficult position. The Code advised that colleagues are morally obliged to support nurses who fulfil their ethical obligations (CNA, 1991). The results of this study indicated that situations existed in which public health nurses and public health nursing administrators had not fulfilled these obligations.
Organizational Variables

The organizational variables identified in this study included acting positions, staffing levels, the role of Central office staff, and the nature of the relationship between the public health nursing administrator and the medical health officer. The influence of organizational variables on nurses' experience of ethical problems was not examined in the nursing literature reviewed. However the overall impact of the organization in which nursing is practiced was discussed in the literature.

Clatterbuck and Proulx (1981) stated that ethical action of nurse administrators implied client advocacy, equitable allocation of scarce resources, and consideration of the nursing staff. It seems that this could be applied to health care organizations as well. In an ethical health care organization the principles of client advocacy, equitable allocation of resources, and consideration of staff well-being would be paramount. The findings of this study unfortunately indicate that the environment in which public health nursing administration was practiced was, to a certain degree, unethical. The frequency of acting positions and the lack of orientation and support for public health nursing administrators holding acting positions are examples of an unethical work environment. The previously discussed lack of autonomy in nursing practice is another example of an unethical work environment. Christensen
(1988) asserted that the considerations for human welfare, which are central to nursing practice, must be applied to nursing staff as well as clients. This study illustrated that consideration for human welfare must apply to nursing administrators as well.

Nursing administrators' obligations to promote an ethical work environment are discussed in the literature (Christensen, 1988; Rodney, 1989). However, within the nursing literature, there is a paucity of information about the obligations of organizations to provide an ethical work environment and the factors which contribute to an ethical environment for nursing administrators.

The findings of this study indicated that inadequate staffing levels had negatively impacted on the participants' experience of the ethical problem. Sietsema and Spradley (1987) also found that nursing administrators identified staffing levels as a concern. In this study, staffing levels appeared to impact the ethical problem in two ways. In situations where there was a shortage of nursing administrative staff in the Health Unit, this impact was related to support. In situations where the administrators identified a shortage of staff public health nursing positions to fulfill the expected program requirements, the staff shortage actually precipitated the ethical problem.

Another organizational factor which influenced the public health nursing administrators experience of the
ethical problem was the role of the Central Office Public Health Nursing staff. As previously discussed, in recent years the role of these senior public health nursing administrators had changed from that of a consultant to that of a program manager. In the current role, opportunities existed for the Central Office staff to develop and implement policies which supported ethical nursing practice. Unfortunately, many of the public health nursing administrators in the field did not perceive that this relationship was supportive. Valuable opportunities to develop an ethical work environment were missed when these senior public health nursing administrators were not utilized.

In two of the situations described by nursing administrators in this study, actions of the Medical Health Officer were perceived to have precipitated the ethical problem experienced (see pages 63 - 64). In analyzing the situations described, it appeared that there was not an ethical relationship between the nursing administrator and the Medical Health Officer. Rodney (1989) stated that in order to implement ethical decision making in nursing we must attend to the organizational climate for professional nursing practice. To Rodney, this meant fostering ethical relationships between nurses and physicians to move nursing out of its powerless position. Aroskar (1985) stated that one component of ethical relationships between nurses and
physicians was mutual respect, based on the inherent worth of all participants in the nurse/physician relationship. In the situations described by two participants in this study, this type of mutually respectful relationship was not evident.

**System Variables**

The system variables identified in this study related to the availability of alternate client services and the communication systems with allied agencies. Duncan (1989) also identified communication systems with allied agencies (Ministry of Social Services) as a factor which influenced the participants' experience of the ethical problem. The influence of this variable illustrated the need for ethical relationships between all health care team members. A mutually respectful relationship between health care team members recognizes the significant contributions that each team member can make, thereby enhancing client care.

**Summary**

In this chapter the study findings were analyzed and discussed in relation to the literature. This discussion included the ethical problems experienced by the public health nursing administrators, the responses to these problems and the variables which influenced the public health nursing administrators' experience of the ethical problem.
CHAPTER SIX

Summary, Conclusions, and Implications for Nursing

In this chapter, a summary of the study is reported and conclusions arising from the study are presented. Finally, implications for nursing practice, education, and research are proposed.

Summary

The intent of this study was to explore the ethical problems encountered in public health nursing administration, public health nursing administrators' responses to these ethical problems, and the variables which influenced the public health nursing administrators' experience of the ethical problem.

Public health nursing is an art and science that synthesizes knowledge from the public health sciences and professional nursing theories (CPHA, 1990). The context of public health nursing practice is complex, including a broad focus of care (communities, groups, families and individuals across their lifespan) as well as a focus on the variables that effect health (lifestyle, family interaction patterns, community resources, economic and social factors, and public policy) (Aroskar, 1979; CPHA, 1990). Public health nurses experience ethical problems in their everyday work. Issues
such as health inequities and confidentiality, as well as the conflicting priorities multidisciplinary team members assign to ethical principles, are potentially problematic.

Although it is acknowledged that nurses in all practice settings experience ethical problems, there has been little focus on the ethical problems encountered by public health nurses (Aroskar, 1979, 1989; Duncan, 1989). Nursing research thus far has focused on ethical problems, ethical dilemmas and ethical decision making amongst nurse administrators in acute care settings (Sietsema & Spradley, 1987; Youell, 1984, 1986). There is no nursing research focused on the ethical problems experienced by public health nursing administrators. Therefore, this study focused on the ethical problems encountered in public health nursing administration.

A qualitative study, incorporating critical incident design, was conducted. Data were collected during audio-taped interviews with twenty public health nursing administrators. The participants in the study were employed by the Ministry of Health in the position of Public Health Nursing Administrator or Public Health Nursing Assistant Administrator. The participants held the position on either a permanent or acting basis.

This study was an adaptation of a study done by Susan Duncan (1989) on ethical conflict and response in public health nursing. The study populations varied somewhat
between the two studies. This study focused on public health nursing administrators. Duncan's study population was broader, including staff and administrative public health nurses, as well as nurses in specialty positions (such as school health).

A semi-structured interview was used as the data gathering technique. An interview guide, developed by Duncan (1989), was adapted for use in this study. The public health nursing administrators were asked to recall an ethical problem they had experienced in the past year. The participants were then asked to describe retrospectively the circumstances, their role, the perceived conflict, options considered, actions taken, outcome, feelings and supportive or inadequate resources.

The audio-taped interviews were transcribed and the data collected during the interviews were analyzed utilizing content analysis to identify common themes. Themes were identified in relation to the ethical problems experienced, the public health nursing administrators' responses to the ethical problem, and the variables which influenced the public health nursing administrators' experience of the problem.

The themes which emerged in relation to the ethical problems experienced were categorized according to the sources of nursing obligations as identified by the CNA in the Code of Ethics for Nursing (1991). These obligations
included clients, nursing roles and responsibilities, nursing ethics and society, and the nursing profession. The response categories, in order of frequency, were nursing roles and responsibilities (70.5%), clients (23.5%), and nursing ethics and society (6%). No problems were identified in relation to the nursing profession. Three participants stated they had not experienced an ethical problem in the past year.

The ethical problems identified in the category of nursing roles and relationships included issues related to protecting clients from incompetence, conditions of employment, and job action. The ethical problems identified in the category of clients included issues related to respect for needs and values of clients, respect for client choice, and confidentiality. Finally, the single response in the category of nursing ethics and society related to an issue of advocacy of the interests of clients/community.

The participants' responses were categorized according to how they acted, felt or thought about the ethical problem they experienced. The responses included stress, regret and uncertainty, utilization of a decision making framework, values clarification, failure to act, the use of personal resources, and the use of external resources.

The variables which influenced the participants' experience of the ethical problem were categorized according to personal, professional, organizational, and system
variables. The personal variables included the presence or absence of previous administrative experience, personal experience, the type and amount of support available. The professional variables related to the degree to which nurses had fulfilled their professional practice obligations. The organizational variables included acting positions, staffing levels, the roles of central office staff, the nature of the relationship between the administrator and the medical health officer, resources, and policies.

**Conclusions**

The following conclusions were based on the analysis of the findings of this study.

1. The public health nursing administrators who participated in this study were able to identify ethical problems in their practice and to retrospectively analyze their experiences.

2. The majority of public health nursing administrators in this study identified ethical problems related to lack of autonomy and conflicting role obligations.

3. The public health nursing administrators all found the experience of the ethical problem difficult. They reported feelings of stress, regret, and uncertainty, and also commented on the amount of work and personal time which was taken up by the experience.

4. The majority of public health nursing administrators
did not feel supported in their experience of the ethical problem.

5. The responses of public health nursing administrators in this study showed a lack of systematic referral to ethical principles as they worked to resolve the problem.

6. Organizational factors existed which made the experience of the ethical problem particularly difficult for public health nursing administrators who held the position on an acting basis.

Nursing Implications

The findings of this study suggest implications for nursing practice, education, and research. The following section will outline these implications.

Implications for Nursing Practice

The findings of this study suggest that in public health nursing administrative practice, as in nursing generally, nurses must continue to clarify roles and work towards increased power in decision making as it affects nursing practice. These steps are part of the process of increasing the autonomy of nursing practice. It is only when nurses are truly autonomous that they can become more ethical.

Public health nursing administrators are leaders in the public health system. As such, they are positioned to
effect change in practices, policies, and organizational structures which do not support nursing practice and therefore do not enable nurses to be ethical. The findings of this study suggest that public health nursing administrators, individually and as a group, must identify and address those issues which interfere with ethical nursing practice.

One primary area of concern which was identified in this study is the phenomenon of acting positions. Public health administrators must address the organizational practices and policies related to acting positions. Participants in this study described situations in which they were placed in acting positions without orientation and without support. Public health nursing administrators must develop policies, orientation packages, and formal support mechanisms which address these concerns. Public health nursing administrators must exercise their considerable positional and political power within the organization to ensure that all staff, including public health nursing administrators themselves, are treated ethically, and that in fact, an ethical organizational culture exists.

The findings of this study also indicated that there is a need for increased awareness of, and attention to, the ethics of public health nursing practice. This role could be fulfilled by the recently organized Public Health Nursing Administrators' Council or, as recommended by Sietsema and
Spradley (1987), public health nursing administrators could discuss at meetings and in the nursing literature the ethical premises on which they should build their practice. The findings of this study suggest that public health nursing administrators must continue to explore ways in which to improve the organization and delivery of health and social services. It is suggested as well that public health nursing administrators, continue to develop ways to build and maintain ethical relationships with multidisciplinary team members.

Implications for Nursing Education

The findings of this study suggest that there is a need for basic and continuing education to increase the ethical knowledge of practicing public health nursing administrators. Of particular importance is information about the process of ethical reasoning and the application of ethical decision making models.

The findings of this study indicate that organizational change is required to address some of the ethical problems which are prevalent in public health nursing administrative practice. In order to initiate and facilitate the change process nurses must develop, strengthen, and utilize skills related to organizational change and the effective use of power and politics. Nursing education can provide this information and provide a milieu in which these skills can be practiced in a non-threatening environment.
Additionally, nursing education, at both the baccalaureate and graduate levels, should provide nurses with the interpersonal and communication skills necessary so that they are able to clearly and confidently express and defend their moral choices.

The findings of this study indicate that public health nursing administrators are seeking further education outside of nursing in order to prepare themselves educationally for their positions. Nursing education must develop relevant master's programs which meet the needs of public health nursing administrators. In order to meet these needs, relevant curriculum must be presented, and the program delivery system must be flexible, including opportunities for part time and distance education.

**Implications for Nursing Research**

This study provided only a beginning exploration of the nature of ethical problems and response in public health nursing administrative practice. This study focused on the ethical problems experienced by public health nursing administrators employed in one organization. Further study, focused on public health nursing administrators employed in other organizations, would help determine whether the ethical problems experienced were organization specific or discipline specific.

The findings of this study indicate that further study to identify those factors which may influence public health
nursing administrators' ability or tendency to perceive the ethical problems in their practice is needed.

This study did not attempt to examine, in detail, the differences which may exist in the ways in which public health nursing administrators in senior and middle management positions experience and respond to ethical problems. This is another area for nursing research.

The findings of this study suggest that further research is needed to examine the appropriateness and effectiveness of ethical decision making models in public health nursing administrative practice.

Policy and its effects on ethical problems in public health nursing practice is an area for further research, as well. Ethical analysis of organizational policies, as well as the policies which influence the health of communities, could be investigated.

**Summary**

In this chapter a summary of the research process was presented and the conclusions were discussed. Implications for nursing practice, education, and research arising from these findings were also outlined in this chapter. It is through reflection upon, and discussion of, the ethical issues faced in nursing practice that competent, confident and ethical practitioners are developed.
1. Direct comparison of the findings of this study with other studies reported in the literature was difficult because this was the only study which focused specifically on the ethical problems experienced by public health nursing administrators. In this discussion, therefore, comparisons are made to studies which focused on the ethical problems experienced by hospital nurses, public health nurses, and hospital nursing administrators.
REFERENCES


APPENDIX A

Information Letter

My name is Allison Cutler. I am a Registered Nurse and a student in the Master of Nursing Science program at the University of British Columbia. For my Master's thesis I have chosen to study ethical problems encountered by public health nursing administrators. Although there is a growing amount of nursing literature on the topic of ethical issues and dilemmas, the majority of this literature focuses on the experiences of acute care nurses and hospital nursing administrators. Your perspective as a practicing public health nursing administrator will provide valuable insights into the ethical dimensions of public health nursing administration.

I would like permission to interview you. This will take approximately 45 - 60 minutes of your time. The interviews will be taped and transcribed. All information obtained will remain confidential through the use of code numbers on the interview transcripts. Your name and the name of the Health Unit in which you work will not be identified in the study. Any names which are inadvertently mentioned during the interview will be deleted when the tapes are transcribed.

You are under no obligation to participate in the study. You may refuse to participate or discontinue your participation at any time. Your participation or non-
participation in this study will not affect your employment status. The names of those participating will not be released.

If you have any questions about this study now or at a later time, please contact me at 758-0042 (home) or 755-6253 (work) or Janet Ericksen at 822-7505.

If you are willing to participate in this study please sign the enclosed consent form and return to me in the enclosed envelope. I will then contact you to arrange a mutually convenient time and location for the interview.

I look forward to hearing from you.

Sincerely,

Allison Cutler
APPENDIX B
Consent Form

Project Title: Ethical problems encountered by community health nursing administrators

My name is Allison Cutler. I am a Registered Nurse and a student in the Master of Nursing Science program at the University of British Columbia. For my Master's thesis I have chosen to study ethical problems encountered by public health nursing administrators. Although there is a growing amount of nursing literature on the topic of ethical issues and dilemmas, the majority of this literature focuses on the experiences of acute care nurses and hospital nursing administrators. Your perspective as a practicing public health nursing administrator will provide valuable insights into the ethical dimensions of public health nursing administration.

I would like permission to interview you. This will take approximately 45 - 60 minutes of your time. The interviews will be taped and transcribed. All information obtained will remain confidential through the use of code number on the interview transcripts. Your name and the name of the Health Unit in which you work will not be identified in the study. Any names which are inadvertently mentioned during the interview will be deleted when the tapes are transcribed.

You are under no obligation to participate in the
study. You may refuse to participate or discontinue your participation at any time. Your participation or non-participation in this study will not affect your employment status. The names of those participating will not be released.

If you have any questions about this study now or at a later time, please contact me at 758-0042 (home) or 755-6253 (work) or Janet Ericksen at 822-7505.

I understand that nature of this study and give my consent to participate. I acknowledge receipt of a copy of this consent form.

Signed: ________________________________

Date: ________________________________
APPENDIX C
Interview Guide

CODE:
Date:

I. Demographic Data:

Number of years experience as a nurse:
Number of years experience as a public health nurse:
Position currently held: PHN/A _____
                      PHN/AA _____
Number of years experience in public health nursing administration:
Nursing education: (Highest level attained)

II. Research Data:

NOTE: It is important to maintain confidentiality for all persons involved in the situation. Please avoid including names of persons, identifying circumstances, or other information that may result in the identification of those involved.

1. Do you encounter ethical problems in your administrative practice?

2. Recalling an ethical problem you encountered in the past year, please begin by describing where the situation occurred and how you came to be involved?
3. What happened? (describe the circumstances)

4. Who was involved?: (please alter names and other identifying information to maintain confidentiality):

5. What was your role in the situation?:

6. What was the conflict of choice that existed for you in this situation?:

7. What were the options or possible actions you considered? (please describe what you intended as the probable consequences of each alternative you considered):

8. Please describe what in your mind was the best decision and what actions were taken.

9. What was the outcome of the situation (if known):

10. What resources were helpful to you as you dealt with this situation? Did you feel you had adequate support?

11. Are there any other resources that may have been helpful to you?

12. What was most difficult about this situation for you?

13. Please describe any other feelings you have or have had about this situation:
April 5, 1991.

Dear Allison

Re: Permission to use thesis questionnaire

As per your request, you have my permission to utilize and adapt the questionnaire I developed for my thesis Ethical conflict and response in community health nursing practice.

Sincerely,