

ETHICAL ISSUES ENCOUNTERED BY NURSES

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ABSTRACT

The purpose of this study was to describe the nature of ethical issues encountered by nurses working on medical/surgical nursing units and the degree to which they found these issues disturbing. Relationships among demographic variables and nurses' experience with specific ethical issues were also examined.

A survey of a stratified random sample of 400 Registered Nurses in British Columbia working on medical/surgical nursing units was completed. The "Survey of Ethical Issues in Nursing - Revised" (SEIN - R) and a demographic form were mailed to each participant. Two hundred and two questionnaires (50.5%) were returned and 196 (49%) used in the analysis.

The findings indicate that nurses perceive that they "rarely" encountered ethical issues as identified in the instrument. The five most frequently encountered ethical issues that nurses reported were: (1) unsafe staffing patterns, (2) family demands for futile treatment, (3) prolongation of life when death was inevitable, (4) unprofessional conduct of a colleague, and (5) disagreements with physicians over patient care. Overall, nurses reported being at least "somewhat" disturbed about the ethical issues they encountered or would have become so if they had encountered these situations in the practice setting. When asked to identify how disturbed they were or would be by the 26 ethical issues included in the SEIN - R, the five most disturbing issues were: (1) working with physicians who demonstrated inadequate knowledge and skills, (2) unsafe staffing patterns, (3) prolongation of life when death was inevitable, (4) caring for a patient whose family was demanding futile treatment, and (5) knowing that information about a patient's prognosis was being withheld from the patient and/or family.

The findings also suggest that a number of statistically significant but weak relationships exist between the five most frequent and the five most disturbing ethical issues, and select demographics.

The most common resource nurses use when addressing ethical issues is their nursing colleagues. Relatively few nurses used their Canadian Nurses Association Code of Ethics for Nursing to guide them in their ethical decision-making; more used the Registered Nurses Association of British Columbia Standards for Nursing Practice.

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CHAPTER ONE: INTRODUCTION

Background to the Problem

Professional ethics are considered by many to be a critical component of conceptualizations of professionalism (Lewis & Maude, 1952; Quinn & Smith, 1987; Valiga, 1982). Lewis and Maude stated that most emphasis in defining professionalism has been centered on standards of conduct or professional ethics. Moreover, professional codes of ethics can serve a variety of purposes for professional groups (Notter & Spalding, 1976). First, they act as guides for new practitioners in understanding their professional responsibilities, rights, and privileges. Second, they provide a basis for determining appropriate or inappropriate professional conduct. Third, they can serve as a basis for regulating the relationships of practitioners to consumers, to the profession itself, to society and to their colleagues. Finally, professional codes of ethics serve as guides for the public in understanding the characteristics of professional conduct.

Nursing ethics have been a major concern since the practice of nursing developed in North America. Nurses have always encountered moral dilemmas in caring for the sick, whether it be in slums or small communities, in industries, during war or disaster, at home or in hospital (Fowler, 1989). Throughout the century, nurses have identified some of the ethical concerns they face in practice, education, and society.

Many changes in the past two decades have intensified the focus on nursing ethics and consequently, the quantity of literature published on this subject has expanded. Nurses are now educated about nursing ethics in basic nursing programs, during inservice sessions, and at nursing conferences. In many health care settings, nurses are

members of bioethical committees.

Various and complex changes in society and the health care system necessitate increased attention to ethical issues (Benoliel 1983, 1993; Storch, 1982). Since medical technology has advanced so dramatically during the past two decades, patients can now live well beyond their expected capacity to survive (Gaul & Wilson, 1990). For example, mechanical ventilators force oxygen into non-functioning lungs, dialysis takes over for failing kidneys, and pacemakers stimulate failing hearts (Strother, 1991). These advances in technology, combined with limited resources, an increased emphasis on consumer rights, and changing relationships among health care professionals produce complex situations that require nurses to make difficult choices and decisions when ethical questions about patient care arise (Buchanan & Cook, 1992). Consequently, nurses have identified important ethical concerns involving honest communication, the withholding of treatment, technological advances and working conditions (Buchanan & Cook).

According to Mayberry (1986), nurses are faced with ethical issues that no longer can be resolved by previous strategies such as guessing, relying on past experience, or intuition. Because nurses experience ethical issues that vary from ordinary to sensational, nurses must be knowledgeable and skillful at making ethical decisions.

Although in recent literature it is suggested that nurses face increasing numbers of ethical issues (Berger, Severson, & Chvatal, 1991; Davis, 1988; Erickson, 1993; Holly, 1993) and more complex issues (Aroskar, 1980; MacPhail, 1988), little nursing research has focused on describing the ethical issues nurses commonly encounter. Studies are needed to identify the kinds of ethical issues nurses face, the frequency with which they deal with them, and the emotional impact various kinds of ethical issues have on nurses.

In particular, studies of the emotional impact of ethical issues experienced by Canadian nurses are lacking. Without this knowledge, the profession lacks a sound foundation for developing educational programs and resources to help nurses deal with ethical issues. Therefore, investigation on the emotional impact of ethical issues, a topic which has not to date been explored in Canada, is required.

Statement of the Problem

As nursing struggles to stay abreast with rapid advances in technology and changes in the health care system, nurses are faced with an increasing number of ethical issues. The literature reveals that nurses are concerned about the variety of ethical issues they encounter in the clinical setting (Fowler, 1989). There is little research to identify the ethical issues Canadian nurses experience in their practice settings. Since the kinds of ethical issues faced by nurses are likely to be directly related to the clinical areas and health care system in which they work, there is a need to explore some of the ethical issues faced by Canadian nurses and what they think about them.

Purpose

The purpose of this study was to describe the experiences of British Columbian nurses working on medical/surgical units in relation to ethical situations encountered and their responses to them.

Conceptualization of the Problem

A profession is often described in terms of a composite of characteristics or attributes. For over 70 years, various scholars have attempted to develop and refine a set of characteristics or attributes which would define the degree of professionalism or the professional status of a discipline (Hall, 1982; Stinson, 1970; Valiga, 1982). Since

Flexner developed a list of characteristics in 1915, various other experts have offered lists of characteristics which occupations could use to determine their achievement of professional status (Bixler & Bixler, 1959; Flexner, 1915; Greenwood, 1957; Hall, 1968; Moore, 1970; Notter & Spalding, 1976; O'Houle, 1980).

Greenwood's (1957) work has been extensively quoted by scholars examining professionalism (Buick-Constable, 1969; Etzioni, 1969; O'Houle, 1980; Stinson, 1970; Vollmar & Mills, 1966). He postulated that five characteristics of a profession form the basis of a profession model: systematic theory, authority, community sanction, ethical codes, and culture. Attainment of professional status is measured by the extent to which the identified characteristics of a profession are seen to be present (Jodouin, 1991). The present study is concerned with the professional characteristic of ethics.

Although there has been no clear consensus on what is required to characterize certain activities as professional, a few experts agree that a principal characteristic of a profession is that its practitioners act as morally responsible agents committed to the purposes of the professional group (Murphy & Hunter, 1983; Quinn & Smith, 1987; Valiga, 1982). Thus, a professional person cannot simply do a job or follow orders without careful consideration and reflection. "To be a professional person is to accept the difficult and demanding need to think through the implications of every phase of one's professional activities" (Murphy & Hunter, p. 5).

With various and complex changes in society and the health care system, nurses are more frequently encountering ethical issues including the prolongation of life, inadequate staffing, the inappropriate allocation of resources, fragmented team decision-making, a lack of informed consent, and unethical or incompetent activities of colleagues

(Aroskar, 1989; Berger et al., 1991; Crisham, 1981; Davis, 1981, 1988; Haddad, 1992; Youell, 1986). Researchers have identified that nurses facing such ethical issues experience a variety of feelings such as anger, frustration, helplessness, powerlessness, anxiety or guilt (Duncan, 1989; Erlen & Frost, 1991; Fenton, 1987; Holly, 1989; Martin, 1989; Quinn, 1993; Wilkinson, 1985). These feelings may be a response to encountering increasingly complex and often emotionally laden ethical issues. Nurses' perceived or actual lack of involvement in moral decision-making, and their inability to resolve ethical dilemmas or moral distress may also cause these feelings. Nurses may experience moral distress when they have made a moral decision but are unable to perform the moral behaviour indicated by that decision (Wilkinson, 1985). Frequently, institutional constraints make it nearly impossible for nurses to pursue their preferred course of action (Jameton, 1984). It has been suggested that these emotional responses to ethical issues are a major source of job stress and an important factor in nurses choosing to leave the nursing profession (Wilkinson). It also is possible that these emotional responses may have a significant impact on the quality of care nurses provide to patients and their families.

Although the literature is replete with anecdotal information about ethical issues, no quantitative research examining nurses' perceptions of ethical issues has been conducted in British Columbia. Therefore, this study focused on the ethical issues nurses encounter in the workplace and how disturbed they were by them.

Research Questions

The research questions were as follows:

1. How frequently do nurses encounter specific ethical issues?

2. How disturbed are nurses by the identified ethical issues?
3. Do nurses use their code of ethics and standards of practice?
4. What resources do nurses report using in resolving specific ethical issues?
5. What are the relationships among select demographic variables and nurses' experience with specific ethical issues?

Definition of Terms

Morals - "refers to professional and personal conviction about how one ought to act and what one ought to believe" (Levine-Aruff & Groh, 1990, p. 19).

Ethics - refers to the systematic study of principles and values. Ethicists question and study what we ought to do, thus providing guidelines for moral conduct (Levine-Aruff & Groh, 1990).

Ethical Issue - a dispute involving different points of view about what constitutes ideal moral conduct or behaviour.

Ethical Dilemma - a situation that arises from conflicting moral obligations, rights and claims. It raises such questions as "what ought I to do? What is the right thing to do? What harm and benefit result from this decision or action?" (Davis & Aroskar, 1983, p.

6). There are no right or wrong answers, only choices between equally unacceptable solutions or alternatives (Fenton, 1987).

Disturbed - to be upset mentally or emotionally; to be made uneasy or anxious (Newfeldt & Guralnik, 1988).

Resource - any thing, person or action to which one turns for aid in times of need or emergency (Newfeldt & Guralnik, 1988).

Significance of the Study

The findings of this research will interest staff nurses, educators and administrators. For example, administrators are concerned about the emotional impact various ethical issues may have on staff nurses. Knowledge about those issues which disturb nurses could help administrators develop strategies to reduce nurses' stress and burnout in the workplace. Ensuring that resources are available and accessible to staff nurses to assist them in resolving specific ethical issues could have a significant effect on the quality of patient care provided and on costs related to turnover. Educators are also concerned about the need to teach nursing ethics based on nursing research. Both student and staff nurses will benefit from educational opportunities that focus on what nurses perceive to be the most commonly experienced ethical issues and those which produce the greatest distress.

Finally, knowledge about what ethical issues disturb staff nurses most could help them and others understand nurses' needs, as well as the emotional impact ethical issues may have both on themselves and on the patients they care for. Indeed, failure to address these issues could negatively influence the quality of care provided by nurses.

Although investigators have begun to associate ethical issues with the phenomena of moral distress, burnout, and job turnover (Wilkinson, 1985), the serious emotional impact of these issues has yet to be adequately investigated. The ethical problems encountered by nurses permeate every facet of the workplace and must be addressed by educators, administrators and staff nurses.

Assumptions

For the purpose of this study, it was assumed that:

1. The responses of the subjects would reflect their actual beliefs.
2. Staff nurses from medical/surgical units experience ethical issues in their nursing practice.
3. Nurses are able to identify clinical situations where ethical issues occur.

Organization of Thesis Content

This study was designed to describe the nature of ethical issues encountered by nurses working on medical/surgical units and how disturbed they were by them. Chapter One delineates the background and significance of the research problem. Conceptualization of the problem, research questions, definitions of terms, significance of the study and assumptions were also identified. In Chapter Two, a review of the relevant literature is presented. In Chapter Three, the research method is described, including the research design and sampling procedure, data collection instruments and procedures, data analysis techniques, limitations of the study and ethical considerations. Chapter Four contains the presentation of the findings of this study. In Chapter Five, discussion of the findings and the conclusions of the study are presented. Implications for nursing practice, education, administration and research are also included in this chapter.

CHAPTER TWO: REVIEW OF LITERATURE

Introduction

The purpose of this literature review is to provide a framework within which to examine the ethical issues nurses face in the clinical setting. The professional model that was used as a framework for this study is described. Then, a review of ethical theory, the Canadian Nurses Association Code of Ethics for Nursing, and ethical research in nursing is presented.

The Professional Model

Experts have extensively analyzed a profession in terms of its characteristics or attributes, often referring to those characteristics as the professional model. Greenwood (1957) suggested that all professions seem to possess the following characteristics: systematic theory, authority, community sanction, ethical codes, and culture. Greenwood's identification of these characteristics helped scholars better understand the nature or "essence" of professions. More importantly, many occupational groups have used this professional model to evaluate their progress towards professional status. Greenwood's model emphasizes the importance of regulatory ethical codes for professionals. He believed that all professionals are compelled to act ethically in accordance with built in regulative codes. The profession's ethical code is partly formal and partly informal. The formal element is a written code of ethics that professionals use to guide them in their practice. The informal code is an unwritten standard of conduct. Greenwood suggested that this imperative carries the same weight as a written document.

Greenwood (1957) fully explored the implications of "professionalism" on the

conduct of the individual. For example, he stated that the professional must remain "emotionally neutral" when working with a client. The professional "must provide service to whoever requests it, irrespective of the client's age, income, kinship, politics, race, religion, sex, and social status" (p. 50). He also believed that the professional is motivated less by self interest and more towards providing a "maximum calibre service." Ethics as one characteristic of professionalism will be examined in this thesis.

Nursing ethics have expanded dramatically since the development of Greenwood's (1957) criteria of a profession. Ethical practice is a concern to not only the individual nurse, but also to professional organizations. For example, because professional organizations direct nursing practice, they play a key role in supporting the development of ethical standards that guide nurses in ethical decision-making.

Nursing has always been faced with ethical issues. Fowler (1989) stated that "for almost 100 years, we have seen nurses living out their ethical concerns in urban slums and tenements, in the backwoods and mountains, in factories and mines, in war and disaster, at home and in more recent times in hospital, and now in the public arena" (p. 956). Although ethics have always been an issue, focus on nursing ethics and ethical decision-making significantly increased in the 1980s (Greipp, 1992).

A number of reasons including the dramatic changes occurring in health care delivery, may explain why ethical issues are now more prevalent for the practicing nurse. The ethical issues of health care, in part, result from new technology, increased costs, a cultural emphasis on individual rights, conflicting social values, and changing relationships among health care professionals (Buchanan & Cook, 1992). Nurses require knowledge and skill about ethical principles to participate with other health care

professionals in making decisions with patients and families. Therefore, as professionals, nurses must be able to "apply appropriate ethical concepts to the cultures in which they work and to be sensitive to the need for thoughtful and sound decision-making in the face of ethical dilemmas" (Curtin & Flaherty, 1982, p. 76).

Ethical Theory

The concept of ethics has many meanings for both the individual and the professional group. "It carries models of moral behaviour, implications of what is right and wrong, and messages related to professionalism and professional rules of conduct" (Fenner, 1980, p. 21). In much of the literature, the terms "morals" and "ethics" are used interchangeably (Davis & Aroskar, 1983; Kelly, 1991; Levine-Ariff & Groh, 1990; Storch, 1982). The word "ethics" comes from the Greek word "ethos," meaning customs, habits, conduct and character (Davis & Aroskar, 1983). The English word "morals" comes from the Latin word "moralis," meaning "manners;" ethics is the theoretical component and morals the applied or practical concern (Thompson & Thompson, 1985).

Health care ethics, also called biomedical ethics, are ethics that are specific to health care situations. Questions are raised regarding what is right or what ought to be done in situations that require action involving others (Davis & Aroskar, 1983). Four interrelated areas that health care ethics specifically address are: the clinical area, allocation of scarce resources, human experimentation, and health policy. According to Davis and Aroskar, discussions of health care ethics function: "(1) to sensitize or raise the consciousness of health professionals (and the lay public) concerning ethical issues found in health care settings and policies, and (2) to structure the issues so that ethically relevant threads of complex situations can be drawn out" (p. 4). Applying the principles

and theories of ethics can assist health care professionals to systematically reason through ethical dilemmas.

Ethical theories do not resolve ethical dilemmas, but provide nurses with guidance in their decision-making. Ethical theories consist of sets of principles that attempt to explain relationships among principles, rules, judgments and actions (Jacobs & Severson, 1988). Some of these theories draw on the principles of autonomy, beneficence, nonmaleficence, and justice (Davis & Aroskar, 1983).

Over the centuries, ethicists have developed broad based theories such as deontology and utilitarianism, which apply ethical principles in a consistent manner (Winters, Glass, & Sakurai, 1993). Deontology is a system of ethical decision-making that is based on moral rules and unchanging principles (Catalano, 1992). Deontologists believe in the ethical absoluteness of principles regardless of the consequences of the decision. In other words, they generally believe that certain actions are inherently wrong, regardless of any positive consequences that may result. For example, a deontologist might believe that it is always wrong to lie to a patient regardless of the circumstances.

Utilitarian ethical theory is based on two underlying principles: one acts in order to achieve the greatest good for the greatest number of people, and the end justifies the means (Thompson & Thompson, 1985). "In practice, the utilitarian does not believe in the validity of any system of rules. That is because the rules can change, depending on circumstances surrounding the decision to be made" (Catalano, 1992, p. 91).

The usefulness of ethical theories for nurses facing ethical dilemmas fragments when theories such as deontology and utilitarian theory compete with each other. For

example, the right of the patient to autonomy may conflict with the nurse's obligation to provide safe care (Cooper, 1991). Thus, the usefulness of traditional principle based theories in addressing ethical issues in nursing has been questioned and has led some nurse ethicists to focus on developing theories specifically for nurses (Fry, 1989a, 1989b).

Nursing ethics refer to the expressed ethical norms of the nursing profession; the values, virtues, and principles that should govern and guide nursing in the practice setting (Yeo, 1991). "These are typically phrased as moral injunctions of the sort 'be truthful with clients' or 'respect client confidentiality.' They may also be expressed as exhortations to adopt and practise particular virtues, such as caring or fairness" (p. 2).

The terms "ethical dilemma," "moral dilemma," "ethical issues" and "ethical problems" are not used in a standardized manner in the nursing literature (Rodney, 1989). Therefore, it is necessary to define them as they pertain to this study. "Ethical issue" is a term frequently used in the nursing literature, although rarely defined. The dictionary states that an issue refers to a point of debate, discussion or dispute (Morris, 1985). As discussed earlier, ethics relate to the study of moral principles and rules of conduct (Levine-Aruff & Groh, 1990). Therefore, for the purpose of this study, ethical issues are defined as disputes involving different points of view about what constitutes ideal moral conduct.

Davis and Aroskar (1983) stated that a dilemma can be defined as "(1) a seemingly difficult problem incapable of a satisfactory solution, or (2) a choice or situation involving choices between equally unsatisfactory alternatives" (p. 6). Ethical dilemmas are situations that arise from conflicting moral obligations, rights and claims. They raise such questions as "what ought I to do? What is the right thing to do? What

harm and benefit result from this decision or action?" (Davis & Aroskar, p. 19). There are no right or wrong answers, only choices between equally unacceptable solutions (Aroskar, 1980). It is important to note that an ethical dilemma may or may not involve a legal issue. Storch (1982) stated, "In some cases the law demands more than ethical standards would demand; in some cases the law differs from ethical standards; and in some cases the law is silent with respect to any ethical standards" (p. 29). According to Aroskar (1980), there are many limitations in law. "Legal decisions often do not provide answers to specific ethical dilemmas confronting health professionals and may create new dilemmas by their very nature" (p. 658).

Although nurses have always been faced with ethical dilemmas, these dilemmas are more complex today for several reasons. First, rapidly expanding medical knowledge and new technologies have made possible dramatic interventions to save or prolong life. This raises the issue of quality versus length of life. Second, the availability of education has created a better informed public demanding more information and involvement in decision-making about its health care. Finally, the quantity of available resources raises questions about the priorities of the health care system, who should receive treatment, and how funds ought to be spent (MacPhail, 1988).

Storch (1988) contended that basic problems, such as prolonging life and treating or ensuring patient autonomy are shared by all health care professionals. She suggested, however, that there is a uniqueness to nursing's ethical dilemmas given their function of "being there," their multiple obligations, and their ceaseless and daily dilemmas about care. When Storch used the term "being there," she referred to the nurse's role in providing 24-hour nursing care. Nurses are, in fact, the only health care providers that

are with their patients on a continual basis. This vantage point offers unique privileges and responsibilities because nurses are privy to patients' hopes, fears and regrets (Bandman & Bandman, 1990). Frequently, nurses form significant relationships with patients and families, demonstrating concern and respect both for those individuals and about fundamental human dignity. Some argue that nurses are, in fact, distinguished by a predominant caring ethic (Canadian Nurses Association, 1980, 1985, 1991). The nurse's continual and caring relationship with the patient and family frequently places him or her in the middle of ethical dilemmas (Storch, 1982). According to Storch, nurses must assume different roles and take on responsibilities that involve obligations to patients, families, colleagues, doctors, and employing institutions. The problem of setting priorities with multiple obligations is the basis of many ethical dilemmas for nurses. More significantly, nurses daily experience ethical dilemmas that vary from the ordinary to the sensational. Their daily obligations require that they understand and be skilled in using ethical principles.

Ethical decision-making is a complex process. "It is based on the concept of moral reasoning: sorting out what is good, what the preferred action is and why, and what are the consequences of the action if it is taken" (Thompson & Thompson, 1988, p. 245). This reasoning process, however, is significantly influenced by the individual's personal, professional and societal values, and his or her level of moral development. Moreover, the individual's knowledge and use of ethical theories will influence his or her choice of what is morally correct action to take in a given situation. Winters et al. (1993) also suggested that "nurses' personal experience and professional education, as well as their background in examining professional statements and working within

institutions, can all affect the manner in which they express or act upon their values" (p. 22). Any of these factors may influence nurses as they choose between competing ethical alternatives.

Decision-making models have been developed as guides for analyzing ethical problems and reaching solutions. One example is a model developed by Curtin (1978a). She suggested that the process incorporates seven factors, including the following: background information on the situation, identification of the ethical components in the situation, identification of those persons involved in the decision-making, identification of possible options and consequences of each option, application of ethical principles and theories, resolution, and action. This model is similar to others in that it incorporates the key elements of situational information, decision-making questions and underlying ethical theories referred to by Aroskar (1980).

Ethical dilemmas involve conflicting moral claims; they may involve moral uncertainty or moral distress. Jameton (1984) stated that "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). This is supported by Wilkinson (1985, 1987/88), who defines "moral distress" as the negative feeling state a person experiences after making a moral decision, but not being able to perform the moral behaviour indicated by that decision due to factors such as institutional constraints. Curtin (1978b) suggested that these constraints come from institutional policies, physicians' orders, and a general disregard for the legitimate authority of the nurse regarding nursing care. In response to this distress, nurses may experience feelings of anger, resentment, guilt, frustration, sorrow, or powerlessness (Erlen & Frost, 1991; Jameton, 1984; Rodney, 1988; Rodney &

Starzomski, 1993; Rushton, 1992; Wilkinson, 1985). For nurses, moral distress may lower their self esteem and affect their personal relationships. It may alter their behaviour and cause physical symptoms. More importantly, their patient care may suffer (Wilkinson, 1987/88).

Only recently have nursing scholars begun to explore nurses' emotional responses to ethical issues, including the moral distress nurses may experience (Fenton, 1988; Jacobs & Severson, 1988; Rodney, 1989; Rodney & Starzomski, 1993; Wilkinson, 1987/88) and the overwhelming impact these responses can have on both nurses and patients. More significantly, emotional responses, such as moral distress may be determining factors in job satisfaction, retention of nurses in clinical practice and quality of patient care (Fenton).

Codes of Ethics for Nursing

A code of ethics consisting of beliefs and laws that regulate conduct is an essential characteristic of a profession. An ethical code is a framework for decision-making and is "by nature of its use, action oriented" (Fenner, 1980, p. 22). According to Beauchamp and Childress (1989), a professional code provides action-guides for a particular group. These action-guides should be justified by reference to more general principles and rules, although these may not be explicitly identified in the codes themselves.

Historically, nursing practice has its roots in an ethical tradition of service to others through promoting and restoring health, alleviating suffering, and comforting of the dying. Isobel Hampton Robb (1860-1910), an outstanding leader in nursing and in the education of students in nursing, wrote the first book on nursing ethics in 1903

(Dolan, 1963; Jamieson & Sewell, 1954; Robb, 1903). Although Hampton Robb (1916) recognized that ethics were intrinsic to nursing practice, no formal code of ethics was written in either the United States or Canada until 1950. In early nursing literature, ethics were referred to as Christian morality. Virtue, purity and discipline were esteemed in the early days of nursing. In other words, nurses were moral and virtuous people who treated their patients accordingly. Nursing then embraced the military philosophy associated with virtues such as loyalty, and norms such as obedience to those of "higher rank" (Winslow, 1990). "Nursing education valued obedience, submission to rules, social etiquette, and loyalty to the physician" (Kelly, 1991, p. 209).

Not until after World War II were formal codes of ethics adopted by national and international nursing associations. In 1955, the Canadian Nurses Association (CNA) adopted the International Council of Nurses (ICN) Code of Ethics which guided nurses in ethical decision-making until the 1970s (MacPhail, 1988).

Despite having a code of ethics, nurses had little voice in ethical decisions regarding their patients prior to the 1970s. In fact, it was during the 1970s that many unethical actions occurred. For example, in an experiment conducted at a Montreal institute in the late 1940s, patients were given drugs without their knowledge, such as lysergic acid diethylamide (LSD) which had serious long term effects (MacPhail, 1988).

Since the late 1970s, nurses have more fully embraced their role as patient advocates (Murphy, 1990; Schattschneider, 1992). Murphy (1990) believed that the general restructuring of societal values and organizational management encouraged this change. "Change began to occur in health care bureaucracies because nurses attempted to gain some authority to make clinical judgements and to involve themselves in clinical

decisions. Nurses wanted to be morally accountable and responsible for the care they provided" (p. 60).

With societal changes occurring in the late 1970s, developing a code of ethics became a priority at the 1978 CNA biennial convention. In 1980, the CNA published its first Code of Ethics, based on the concept of caring. This code was revised in 1985 and 1991 with content changes reflecting the evolution of nursing and its philosophy (Dunphy & Mercer, 1992). Nurses in Canada are now guided by the Canadian Nurses Association Code of Ethics for Nursing. When faced with ethical dilemmas, the code of ethics articulates standards that nurses are to uphold.

Research on Nursing Ethics

Although much anecdotal literature offers guidance in making moral decisions, relatively few research studies have been conducted focusing on the ethical issues nurses face in the workplace (Davis, 1981; Duncan, 1992). A number of studies have addressed the issue of moral judgement and ethical decision-making (Crisham, 1981; Ketefian, 1981; Lamb, 1985; Mayberry, 1986; Murphy, 1984). Since this research was not specifically related to the research questions posed in this thesis, it was not included in the literature review. This section of the literature review examines the existing research on ethical issues within nursing. Areas reviewed were the following: (a) codes of ethics; (b) ethical issues encountered by nurses; and (c) responses to ethical issues.

Codes of Ethics

An extensive review of the literature revealed only one study that examined nurses use of codes of ethics. In an American study examining nurses use of a code of ethics, 1,600 nurses from eight western U.S. states were asked if they had a copy of their

Code For Nurses (Miller & Adams, 1991). The findings revealed that, of the 514 responding nurses, only 205 (40%) knew much about their code. Although most respondents did not have a copy of their code, they indicated that adherence to the code was essential to the professional nurse.

Ethical Issues Encountered by Nurses

During the 1980s, 17 studies were completed describing the kinds of ethical issues nurses face in their workplace. These included eight quantitative surveys, some of which had sample sizes ranging from 100 to 319 nurses (Aroskar, 1989; Berger et al., 1991; Davis, 1981, 1988; Haddad, 1992; Holly, 1989; Miya, Boardman, Harr & Keene, 1991; Sietsema & Spradley, 1987) and seven qualitative studies (Crisham, 1981; Erlen & Frost, 1991; Holly, 1993; Martin, 1989, 1990; Rodney, 1987; Youell, 1986). Two of the studies specifically focused on ethical issues faced by nurse administrators (Sietsema & Spradley, 1987; Youell, 1986).

Davis (1981) conducted a survey of 205 staff nurses, administrators, teachers and other clinical nurses. Her research focused on both the extent to which nurses understand the concept of ethical dilemma and the content of the ethical dilemmas they confront. An open-ended question format was used to gather data so that participants could indicate those ethical dilemmas they found to be particularly troublesome. The participants, rather than the researchers, defined the ethical dilemmas. The findings revealed that the majority of respondents clearly understood what constitutes an ethical dilemma. One of the most frequently occurring dilemmas nurses reported involved whether or not life should be prolonged using heroic measures. Another major dilemma involved nurses' choices about the unethical or incompetent activity of colleagues.

However, the exact nature of those conflicts was not reported in the study. Davis concluded that nurses need to be involved in more dialogue about ethical decision-making and ethical reasoning to help them clearly articulate their ethical positions.

Crisham (1981) interviewed 130 volunteer staff nurses during which they were asked to describe a nursing dilemma they had experienced. From these interviews, 21 recurrent nursing moral dilemmas were identified. These were grouped according to four underlying ethical issues: "deciding right to know and determining right to decide, defining and promoting quality of life, maintaining professional and institutional standards, and distributing nursing resources" (Crisham, p. 106).

Youell (1986) interviewed 31 senior-and middle-level nurse administrators to determine their most common and difficult ethical problems. The findings were similar to those of Davis (1981) and Crisham (1981) and revealed that the competence of nursing staff, resource allocation, and issues related to death and dying were difficult ethical issues for administrators. However, Youell's study also identified other difficult issues unique to administrators. These issues related to clinical areas, information sharing about staff, honesty, and the appropriate use of information.

Sietsema and Spradley (1987) conducted a survey of the chief nurse executives of 176 acute care hospitals in Minnesota. The instrument developed by the investigators consisted of closed-and open-ended questions based on information gathered from the literature. The instrument was pretested by a group of nursing executives. Face validity was established through the use of content experts. Of the 176 questionnaires mailed, 127 (72%) were returned. The findings indicated that hospital chief executives most

often cited the use of resources and quality of care as their potential major dilemmas. Nurse executives also reported that in addressing ethical issues, they drew on their personal values and turned to nursing and administrative colleagues for support.

Based on the questionnaire used in her 1981 California study, Davis (1988) surveyed 100 nurses in eastern Canada to determine the types of ethical dilemmas faced by Canadian nurses, the factors affecting such dilemmas, and the nurses' understanding of the concept "ethical dilemma." Most respondents worked with adult patients in hospitals as staff nurses or head nurses and had been practicing at least 15 years. As with the previous study, the participants, rather than the researcher, defined what constituted an ethical dilemma. Contrary to the 1981 study findings, Davis found discrepancies between nurses' definitions and their understanding of the concept of ethical dilemma. Rather than define the term ethical dilemma, some respondents described specific ethical dilemmas to demonstrate their understanding of the concept. The four most commonly cited situations were the sustaining of life without regard for the quality of a person's life, participating in abortions, following doctors' orders with which the nurse did not agree, and breaking promises of confidentiality. In her earlier study, Davis (1981) found that the unethical or incompetent activity of colleagues was a major dilemma for nurses. This was not identified as a commonly cited concern for the respondents in the latter study.

Some of the more recent research includes Aroskar's (1989) survey. In this study, questionnaires were sent to over 1,000 staff nurses employed in community and public health agencies to determine what nurses considered their most significant ethical decision-making problem. The response rate for this study was not clearly stated. Of

the numerous concerns this study identified, some of the emerging themes were similar to those in previous studies. Significant ethical problems included conflicts regarding resuscitation orders, patients not being fully informed about their health status, the right of patients to make decisions about their treatment, incompetent nurses, and the allocation of resources.

Rodney (1987, 1988) explored nurses' views about prolonging life. A phenomenological approach involving unstructured interviews with eight critical care nurses was used to generate the data. The participating nurses were employed in tertiary hospitals in the Vancouver area. Rodney determined that nurses' ethical dilemmas generally relate to an overall theme of "senselessness." The term "senselessness" was used to describe the experiences of patients and family members, the activities nurses found themselves involved in to implement treatment regimes; and, in particular, the decision-making processes nurses experienced. From her interviews with intensive care nurses, Rodney identified the following themes: inadequate involvement of the patient, family, and nurse; and fragmentary team decision-making.

Erlen and Frost (1991), Holly (1989), and Martin (1989) reported similar findings to those of Rodney (1987). In Martin's qualitative study, 83 registered nurses from five neonatal intensive care units were asked to discuss their participation in resolving ethical dilemmas for infants with severe congenital anomalies. The findings revealed that 85% of the nurses did not participate substantially in decisions to initiate or forego life-sustaining treatment for their infant patients, yet they were primarily responsible for implementing those decisions.

Likewise, Holly (1989), in her survey of 45 critical care nurses from six hospitals

in New York State, sought to determine how ethical decisions were made in hospitals, and to describe nurses' participation in that decision-making. The majority of nurses (74%) reported that most ethical decisions were made by physicians and that there was limited involvement of patients, families, or nurses. Erlen and Frost (1991), in their qualitative study of 25 nurses working in medical/surgical and critical care settings, also reported that nurses often felt powerless when unable to participate in decisions related to patient care. In each of these four studies, the fact that nurses were excluded from the decision-making process was a significant ethical issue for them.

Martin (1990) examined the nature and prevalence of ethical dilemmas encountered by nurses who care for patients hospitalized with AIDS-related illnesses. Additionally, she considered the intensity and duration of ethical dilemmas in relation to the respondents' perceptions of occupational stress and burn-out. Coping strategies employed by nurses in response to their stress were also studied. Seventy-five registered nurses employed in a large urban hospital provided the sample. Data were collected using three different methods: a) semi-structured interviews with a sample of 25 nurses, b) a series of group interviews with three sets of 10 to 15 nurses, and c) nurses' responses to the AIDS Ethical Dilemma Scale. Martin found that most respondents experienced many ethical dilemmas when caring for AIDS patients. Most frequently reported were dilemmas related to dying and the inevitability of patient death. One dilemma arose from conflicts with physicians and family members over decisions to use aggressive treatments. Other dilemmas included whether or not to resuscitate patients, withdraw therapies, or assist in patient suicide. A second category of reported ethical dilemmas related to the nurses' attempts to help control patients' pain and illness

symptoms.

In a recent study conducted by Miya et al. (1991), 37 volunteer registered nurses were asked to describe those ethical issues they faced in a neonatal intensive care unit, and to identify conflicts for those who faced those issues. The participants were employed both full-and part-time in a 34 bed medical center. Respondents were asked to complete both a demographic form and the Moral Conflict Questionnaire (MCQ). The open-ended MCQ was designed by S. Fry to elicit nurses' descriptions of ethical issues in nursing practice (Miya et al., 1991). A qualitative approach for analysis was used to interpret the descriptive data. The nurses in this study identified a number of issues related to the treatment of infants. Most frequently identified issues included the following: issues involving suffering, pain, and humane treatment; issues of futile treatment and the withdrawal of treatment; issues of treatment versus non-treatment; issues of ordinary versus extraordinary treatment; and issues related to the quality of patients' life. Miya et al. concluded that occasionally nurses found it difficult to function objectively as caregivers when faced with unresolved treatment and communication issues. More significantly, the nurses' conflict in such situations affected stress levels and subsequent job satisfaction.

Berger et al. (1991) conducted a survey of 52 nurses from a large metropolitan hospital in order to identify the frequency with which they experienced specific ethical issues in their practice. These investigators reported that the five most frequently encountered ethical issues, in order of importance, involved inadequate staffing patterns, life prolonged through heroic measures, inappropriate resource allocation, situations where patients were being discussed inappropriately, and irresponsible activities of

colleagues. Nurses in this study also reported that they consulted nursing colleagues and drew on their own personal values in resolving ethical issues. Finally, neither education, age, nor experience was significantly related to the frequency of issues reported. These findings need to be interpreted with caution because of the response rate and small sample size, and the use of only one hospital to obtain a sample.

In a pilot study, Haddad (1992) surveyed 30 home care providers in order to describe ethical problems from their perspective and to refine a survey instrument for a further study of home care providers. The instrument was an 18-item questionnaire developed by the author. To ensure clarity, the tool was pretested with community health nursing students and several community health nurses. The author established face validity based on a review of the literature and personal experience as a home care provider. A random sample of 50 home care providers, from home health aides to agency administrators, was chosen from ten home care agencies. Of the 50 surveys, 30 were returned for a 60% response rate. Haddad reported that the most commonly cited ethical problems were difficulties with payer regulations and the competence of co-workers. The findings also revealed that only six respondents were registered nurses and three were nursing supervisors. Hence, because of the small sample size, these findings cannot be generalized to home care practice or other health care settings.

More recently, Holly (1993) conducted a qualitative study that also asked nurses to describe both a personally encountered, work-related ethical situation and their feelings about being in that situation. Sixty-five full-time acute care nurses employed in four suburban and urban hospitals volunteered to participate in the study. Sixty-seven percent of the sample worked in critical care areas. Three categories derived from the

ethical situations described were exploitation, exclusion, and anguish. Exploitation was defined as treating seriously ill patients or families without considering them as individuals. For example, patients were often subjected to painful and invasive procedures when their prognosis was poor. Nurses were also concerned about the aggressive treatment of terminally ill patients. Of most concern, however, was the emotional and physical harm aggressive treatment often inflicted on patients and their families. Exclusion was defined as a disregard for patients' choices to accept or refuse treatment, and the failure to provide enough information for patients and their families to make informed decisions. For example, nurses reported instances in which physicians and families used personal sets of values rather than addressing the patients' wishes.

Because only 17 studies that explored ethical issues were found, the findings may not accurately reflect what the majority of nurses view as ethical issues. However, similarities about what constitutes ethical issues for nurses participating in these investigations include the allocation of resources (Aroskar, 1989; Berger et al., 1991; Crisham, 1981; Sietsema & Spradley, 1987; Youell, 1986), the competence of nursing staff (Aroskar, 1989; Berger et al., 1991; Davis, 1981; Haddad, 1992; Youell, 1986), and issues related to death and dying (Berger et al., 1991; Crisham, 1981; Davis, 1981, 1988; Holly, 1993; Martin, 1990; Miya et al., 1991; Youell, 1986). Nurses also identified their lack of involvement or exclusion from participating in ethical decision-making about their patients as ethical issues (Erlen & Frost, 1991; Holly, 1989; Martin, 1989; Rodney, 1987). Nurse administrators also identified information sharing about staff, honesty, and the appropriate use of information (Youell, 1986), and quality of care (Sietsema & Spradley, 1987) as ethical issues. Davis (1988), Haddad (1992), Martin (1990), and Miya et al.

(1991) had study findings that differed markedly from the others. Davis (1988), in her Canadian study, reported that nurses encountered issues related to participating in abortions, following doctors' orders with which they did not agree, and breaking promises of confidentiality. Haddad identified difficulties with payer regulations as a major ethical issue for American nurses. Martin (1990) found that nurses experienced ethical dilemmas related to conflicts with physicians and family members over decisions to use aggressive treatments; whether or not to resuscitate patients, withdraw therapies, or assist in patient suicide; and nurses' attempts to control patients' pain and illness symptoms. Miya et al. concluded that nurses found it upsetting and difficult, at times, to function objectively as caregivers when faced with unresolved treatment and communication issues.

Responses to Ethical Issues

Recently, nursing researchers have begun to identify the need to explore how nurses respond to the ethical issues they face in their practice settings. In order to address this problem, researchers are focusing on nurses' emotional responses, their experience of "moral distress," and the impact these responses have on both nurses and patients.

Over the past ten years, 11 studies were conducted describing ethical issues experienced by nurses, as well as their feelings about those issues. Eight of the studies were qualitative, four of which focused on the concept of moral distress (Fenton, 1987; Quinn, 1993; Rodney, 1987; Wilkinson, 1985). All of the studies were conducted in large urban hospitals.

Wilkinson (1985) conducted the first study focused on the concept of moral

distress as experienced by staff nurses working in hospitals. The term "moral distress" referred to the negative feeling state a person experiences after making a moral decision, but not being able to perform the moral behaviour indicated by that decision. A random sample of 382 nurses was chosen from two metropolitan areas. A letter was sent to each of these nurses requesting a response from those who had experienced moral distress. Twenty-four nurses responded by postcard, indicating that they would be willing to participate in this qualitative study. Thirteen of the 24 nurses worked in various areas as staff nurses and 11 were no longer practicing nurses. The researcher used a semi-structured interview format, opening the interview with a definition of moral distress. Study findings revealed that subjects had frequently experienced moral distress in their practice. The most common situations producing this distress involved the prolongation of life, the performance of unnecessary tests and procedures, and truth-telling. These nurses reported feeling angry, guilty, frustrated and saddened. Further, Wilkinson stated that the nurses experienced ongoing feelings of moral distress that affected their personal wholeness; the patient care they provided; and, for some, their decision to leave bedside nursing. In some cases, the informants chose to leave the nursing profession altogether.

Fenton (1987) and Rodney (1987) also explored the concept of moral distress. Fenton conducted semi-structured interviews with five instructors and five recent graduates of an intensive care nursing program in a large acute care hospital. Results indicated that nurses were most distressed by situations involving excessive therapy and the discontinuation of therapy. According to Fenton, the participants described periods of emotional distress that sometimes required considerable time to resolve.

Rodney (1987) offered another perspective from that of Fenton (1987). From her open-ended interviews with eight intensive care nurses, Rodney identified that nurses' inability to function as free moral agents in our health care system was the main cause of moral distress. Rodney used Jameton's (1984) definition of moral distress as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6).

Quinn (1993) conducted one of the more recent qualitative studies that sought to describe how nurses explained their use of physical restraints with elderly patients, and to examine whether or not these nurses perceived the restraint decisions to be a moral problem. Data were obtained from open-ended interviews with 20 female registered nurses working on a medical-surgical unit. These nurses expressed that they disliked physical restraints, and that they experienced varying degrees of discomfort associated with restraint use. Most often, participants described feeling "bad," "really uncomfortable" or "guilty" when a conflict arose between the patient's right to self-determination and the nurse's responsibility to act in the patient's best interests. Although none of the nurses interviewed in this study used the terms "moral conflict" or "moral problem," often in assessing restraint situations, participants were attempting to balance conflicts among personal and professional values.

In summary, the qualitative study findings revealed that nurses reported three common situations that produced moral distress. First, Rodney (1987) identified that nurses' inability to implement their moral choices resulted in expressions of moral distress. Second, Quinn (1993) found that nurses experienced moral distress when a conflict arose between the patient's right to self-determination and the nurse's

responsibility to act on behalf of the patient. Third, nurses experienced moral distress when faced with specific situations, such as those involving the prolongation of life, the performance of unnecessary tests (Fenton, 1987; Rodney, 1987; Wilkinson, 1985) and the discontinuation of therapy (Fenton). Common feelings expressed by those nurses included anger, frustration, sadness (Wilkinson, 1985), guilt (Quinn, 1993; Wilkinson, 1985), agitation (Fenton), and feeling bad or uncomfortable (Quinn). Further, both Fenton and Wilkinson reported that withdrawing from the situation, avoiding the patient, and leaving their jobs were behaviours that nurses used in order to cope with the moral distress they were experiencing.

Seven additional studies, although not specifically examining moral distress, have identified feelings nurses experience when facing ethical dilemmas. Martin (1989) investigated the extent and nature of nurses' reported participation in resolving treatment dilemmas for infants with severe congenital anomalies. A semi-structured interview was conducted with 83 registered nurses from neonatal intensive care units in five large urban hospitals. Results indicated that 85% of the nurses did not participate substantially in decisions to initiate or forego life-sustaining treatment for their infant patients, yet they were primarily responsible for implementing those decisions. Seventy percent of the nurses indicated that not participating in making decisions was a major source of occupational stress and ethical anguish. These nurses reported feeling angry and frustrated at how little they were involved in these decisions. Further, Martin suggested that nurses' "inability to participate in such critical decisions was serving as a major source of stress and may have a substantial impact on burnout and turnover among this group" (p. 471).

Holly (1989) administered a survey to 45 critical care staff nurses to determine how they viewed their sources of support when they had to make ethical decisions. She also examined how ethical decisions were made in their hospitals, and how that affected nurses' participation in ethical decision-making. The respondents represented a variety of critical care areas from six hospitals in New York State. These nurses constituted a 30% response rate. First, Holly found that nurses involved in ethical dilemmas felt frustrated, angry and alone; and perceived that most support came from their nursing colleagues. Second, the majority of nurses surveyed (74%) reported that most ethical decisions were made by physicians and that there were limited roles for the patient, family or nurse. These findings were similar to those of Rodney (1987).

Duncan (1989) interviewed a purposive sample of 30 community health nurses. Her qualitative analysis revealed that community health nurses found their experiences with ethical conflicts difficult. Feelings reported included anger, guilt, frustration and fear. Similar findings were reported by Erlen and Frost (1991) in their qualitative study of 25 nurses practicing in medical, surgical and critical care settings. Nurses indicated that they often felt powerless when unable to participate in decisions related to patient care. Although these investigators focused on powerlessness, they found that nurses' inability to resolve ethical issues resulted in anger, frustration, and exhaustion.

Martin (1990) interviewed 75 registered nurses from a large urban hospital to determine the nature and prevalence of ethical dilemmas encountered by nurses who care for patients hospitalized with AIDS-related illnesses. Martin found that most respondents reported many ethical dilemmas when caring for AIDS patients. These nurses also consistently reported being frustrated and feeling powerless because they

were frequently unable to comfort many of the patients, especially those who were extremely ill and dying.

Berger et al. (1991) completed a quantitative study to determine the frequency with which nurses experienced specific ethical issues in their practice, and to examine how much those issues disturbed them. Nurses were asked to describe how disturbed they felt when encountering certain ethical dilemmas. Subjects responded to each question using a Likert scale ranging from 0 = "not at all" disturbed to 4 = "a great deal" disturbed. This study was conducted in one hospital in a large metropolitan area in the United States. Of the 104 questionnaires distributed, 50% were completed. The study findings revealed that the five most disturbing ethical issues were inadequate staffing, the provision of treatment despite patients' objections, the prolongation of life with heroic measures, acting in opposition to one's personal principles, and incidents of patient abuse. Education, age nor experience were related to the amount of disturbance reported.

Recently, Holly (1993) conducted a quantitative study which asked 65 full-time acute care nurses to describe both a personally encountered, work-related situation, and their feelings about being in that situation. Nurses' emotional experience surrounding ethical situations emerged as a major theme in this study and was labelled as "anguish." This theme reflected nurses' personal feelings arising from situations where nurses felt powerless to assist patients or practice in a professional manner. "Nurses used such words and phrases as nightmare, grief, headache, miserable, painful, sad, dread, sorrow and ineffectiveness in describing the practice situations" (p.113). Holly concluded that dealing with these issues on a daily basis frustrated nurses and that, although nurses

wanted to participate in ethical decision-making, many environmental barriers impede their involvement. "The barriers identified included lack of support, time pressures, personal concerns over security, and hierarchic forces within the institution" (p. 110). More importantly, Holly suggested that nurses' inability to act on the patient's behalf may be contributing to high turnover rates and the nursing shortage.

In summary, common feelings expressed by the nurses from these studies included anger (Duncan, 1989; Erlen & Frost; Martin, 1989), frustration (Duncan, 1989; Erlen & Frost; Holly, 1989; Martin, 1989, 1990), guilt, fear (Duncan), being alone (Holly), and exhaustion (Erlen & Frost). Holly reported that nurses' experience of anguish was reflected in their expressed words and phrases.

Summary of Literature Review

Although a limited number of studies have been completed, the findings provide an important foundation for further research. The kinds of ethical issues that nurses commonly encounter have been identified. In addition, researchers are focusing more attention on nurses' responses to ethical issues, including the phenomenon of moral distress, and the overwhelming impact it has on nurses in the practice setting. Nursing researchers have significantly contributed to our understanding of the impact moral distress can have on nurses.

Most of the research studies directly relate to intensive care nurses and to the American health care system. Few studies have focused on medical or surgical nurses and how disturbed they are by the ethical issues they face caring for their patients and families. This study was based on research conducted by Berger, Severson and Chvatal (1991) and conducted with a Canadian sample of nurses.

CHAPTER THREE: METHODS

Research Design

A descriptive design with a structured, mailed survey questionnaire was used for this study.

Sampling Procedure

The population for this study consisted of the 6,463 practicing medical/surgical staff nurses registered with the Registered Nurses Association of British Columbia (RNABC) on March 1, 1993. A Registered Nurse is a person who is a graduate of an approved school of nursing, a member of the RNABC, and licensed to practice nursing in British Columbia. A stratified random sample of 400 nurses employed full time was drawn from this population. To ensure that an equal number of staff nurses were drawn from small and large hospitals, the RNABC divided the sample population into two geographical areas, urban and rural. The urban area was comprised of the Lower Mainland and Victoria. The rural area included northern Vancouver Island, as well as the north and the interior of the province. From each of these areas, a random sample of 200 staff nurses was drawn.

The number of subjects required for this study was calculated according to Cohen (1977) so that there was an adequate power for tests of significance for all calculated Pearson's Product-Moment Correlation Coefficients (r). A sample size of 250 was desirable at a significance level of 0.05 (α), with a medium effect size of 0.30, and power of at least 99.5%, using a two-tailed test. Given an expected return rate of 60%, 400 questionnaires were mailed to ensure this sample size and an adequate representation of nurses from both rural and urban hospitals.

Data Collection Instrument

The study instrument, Survey of Ethical Issues in Nursing (SEIN), consisted of four sections. Section one was designed by Jacobs and Severson (1988), and revised for the present study. Sections two, three and four were developed by the investigator.

In the first section of the questionnaire, the respondents were presented with 26 statements, each comprising an ethical issue that nurses may encounter in their practice settings. For each statement, respondents were asked to make two responses. The first response referred to how frequently they encountered each stated ethical issue. Subjects responded by using a five-point Likert scale, ranging from 0 = "never" to 4 = "very frequently," the total resulted in a "Frequency" Subscale score. The second response sought to elicit how disturbed nurses were by each issue encountered or would get if they encountered it, resulting in a "Disturbed" Subscale score. Subjects also responded to these statements using a Likert scale ranging from 0 = "not at all" disturbed to 4 = "a great deal" disturbed. Possible scores for each of the two subsections ranged from 0 to 104. One additional question (27) was added to this section by the investigator and requested respondents to identify ethical issues faced in the past year which were not described in the preceding 26 questions.

The second section of the questionnaire consisted of four questions (28-31) that asked the participants about their familiarity with and use of the Canadian Nurses Association (1991) Code of Ethics for Nursing and the RNABC (1992) Standards for Nursing Practice in British Columbia. Respondents were asked to circle yes or no for each of the statements. Section three (question 32) asked the respondents to indicate, from a list of resources, those which they had used in the past year to help them resolve

ethical issues.

Questions on demographics formed the basis of section four of the instrument. Subjects were asked for information about their age, gender, highest level of nursing education completed, areas of current employment (i.e., medical, surgical or medical/surgical unit), number of years as a practicing nurse, length of experience in a medical or surgical area, size of hospital according to bed numbers, and the city/town where their hospital was located.

Jacobs and Severson (1988) developed the original questionnaire (ie. section one of SEIN-R) based on personal experience, the literature, and input from practicing nurses and colleagues. The original instrument contained 28 statements. The authors reported that face validity for the SEIN was established by asking a panel of American experts to review the instrument for completeness of domain, and for clarity and understanding of items. All recommendations were incorporated into the instrument. No reliability or other forms of validity for the tool were reported.

For the purpose of this study and prior to content experts reviewing the SEIN questionnaire, minor revisions were made in the wording of statements and one statement was deleted because it was deemed redundant. Three clinical experts who were knowledgeable about ethics in Canadian nursing were then asked to review the questionnaire for relevance and clarity of items. Each expert reviewed all statement items for their relevance by using a three point ordinal rating scale, as suggested by Lynn (1986), where 1 = "not relevant" and 3 = "very relevant." Second, the experts rated all items for their clarity by using a three point scale, where 1 = "not clear" and 3 = "very clear." In addition, the experts were asked to identify areas of omission and to suggest

areas of item improvement or modification.

The three content experts rated all statements as highly relevant. However, when examining the statements for clarity, they indicated that many were repetitious or inappropriately worded. Several areas of omission were also identified. Based on recommendations from the content experts, the questionnaire was revised. Ten statements were completely rewritten and six required minor changes in wording. Six statements were deleted, and five new statements added, resulting in 26 statements.

Pilot Test

The "Survey of Ethical Issues in Nursing - Revised" (SEIN - R) (see Appendix A) and the other items developed for this research were pilot tested at a Lower Mainland acute care hospital with a sample of ten volunteer medical/surgical staff nurses. To establish test-retest reliability, the nurses in the pilot sample completed the revised version of the questionnaire and completed it again two weeks later. The Pearson's Product-Moment Correlation Coefficient (r) was used to compute the reliability estimates of each subscale. Results of the reliability analysis indicated moderately low coefficients; the Frequency Subscale was 0.57 and the Disturbed Subscale was 0.35. This spuriously low estimate of stability could result from the small sample size in this pilot test. Streiner and Norman (1992) cited sources that recommend having 200-300 subjects in order to establish test-retest reliability. In addition, the subjects were asked to make recommendations regarding the clarity and relevance of the statements. Minor wording changes were made to Sections II and III of the tool. The confidentiality of completed questionnaires was protected by the investigator. The nurses who completed the pilot test were exempted from the sample selection for the study.

Data Collection Procedure

The RNABC mailed a package to each of the selected subjects and their identities were not revealed to the investigator. The package sent to each subject included a letter of explanation, which informed the subjects of their random selection and explained the purpose of the study (see Appendix B), the SEIN-R, and an addressed, stamped return envelope. Participants were asked to answer all questions and to return the questionnaire within a four week time period.

When the questionnaires were received, each was checked for completeness. The date and number of incoming questionnaires were recorded in a log book. Response rates were also noted. Two weeks following the original mail-out, a thank you/reminder letter was sent to each participant. The investigator thanked those who had returned the questionnaires and reminded those who had not yet mailed in the questionnaires to complete and return them.

Data Analysis

The raw data obtained from the questionnaires were entered into a computer file. The Statistical Package for the Social Sciences (SPSS) computer program was used to analyze the data. Both non-parametric and parametric tests were used. To answer research questions 1 through 3, frequency distributions and descriptive statistics were used. To answer question 4, Pearson's Product-Moment Correlation Coefficient (r), Hotelling's t test, Multivariate Analysis of Variance (MANOVA), and Fisher's Least Significant Difference (LSD) were used.

Limitations

The limitations of this study relate to the following:

1. Nurses who participated in this study were those willing to give their time and energy for research, and thus may not represent all nurses. It is also not known how the respondents may have differed from the non-respondents. This limits the generalizability of the findings.
2. The sample did not include staff nurses working in all clinical areas. Therefore, conclusions can only be generalized to other staff nurses working in similar medical/surgical areas.
3. Perceptions of the participants are those held at one point in time. No attempt was made to study changes over time.

Ethical Considerations

The names of staff nurses were randomly selected from the computer bank maintained at the RNABC. To ensure confidentiality and anonymity, the study questionnaires were mailed by RNABC personnel. A cover letter to explain the purpose of the study, to request the subjects' participation, and to promise anonymity was included. It was acknowledged in the letter that the completion and submission of a questionnaire indicated consent to participate in the study. The proposal for this study was approved by The University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects before data collection began.

Summary of Methods

This chapter described the research design used, the sampling procedure, data collection instruments and procedures, the pilot test, methods of data analysis, limitations of the study, and ethical considerations. A descriptive design with a structured, mailed survey questionnaire was used for this study. A stratified random sample of 400 medical/surgical nurses employed full-time in British Columbia was generated by the Registered Nurses Association of British Columbia. The "Survey of Ethical Issues in Nursing - Revised" (SEIN-R) was used to determine the frequency with which nurses experienced specific ethical issues in their practice, and to examine how much those dilemmas disturbed them. The questionnaire was modified from one designed by Jacobs and Severson in 1988. Sections two, three and four were developed by this investigator. The SEIN-R was pretested at a Lower Mainland acute care hospital. Once the proposal for this study was approved by The University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects, the questionnaire, cover letter and stamped return envelope were sent to the selected random sample of staff nurses. Both non-parametric and parametric tests were used to analyze the data.

CHAPTER FOUR: PRESENTATION OF FINDINGS

Introduction

The presentation of the findings is arranged in three sections. In the first section, a description of the demographic characteristics of the sample is provided. Next, the findings related to each of the five research questions are presented. Finally, a summary of the findings is provided.

Characteristics of the Sample

The study sample consisted of 196 registered medical/surgical staff nurses who worked full-time in hospitals throughout British Columbia. A total of 400 questionnaires were mailed, and two weeks later a reminder letter was sent. Of the 202 questionnaires returned, four were returned not completed. Two additional completed questionnaires were disqualified as the respondents worked in areas other than medical/surgical nursing.

Two hundred and two questionnaires were returned for a return rate of 50.5%, and 196 (49.0%) were used in the statistical analysis. This is a satisfactory response rate considering the lack of contact participants had with the researcher. However, since it is difficult to determine how the responses from the 196 respondents would differ from those of the 204 non-respondents, the generalizability of these findings is limited.

The following demographic information was collected from the subjects: age, gender, highest level of nursing education, area of current work, number of years of nursing experience, number of years worked on medical and/or surgical nursing units, hospital bed size where the subject is employed, and city or town in which the hospital is located. Respondents ranged in age from 23 to 65 with a mean age of 38 years ($SD = 9.58$). Forty percent of the nurses were under the age of 35. Nurses between the ages

of 35 and 44 comprised the second largest group at 32.1%. Approximately 20% of the nurses were between the ages of 45 and 54, and only 5.1% were over 55 years (see Table 1).

Table 1

Age Distribution

Age (Years)	Frequency	Percent
Under 35	79	40.3
35 - 44	63	32.1
45 - 54	39	19.9
55 and over	10	5.1
Missing data	5	2.6
Total	196	99.9

Of the 196 respondents, 185 (94.4%) were female and seven (3.6%) were male. Four of the respondents (2.0%) did not indicate their gender.

The highest level of nursing education of the respondents is presented in Table 2. The majority of nurses (86.2%) possessed a diploma in nursing, having completed either two or three years of nursing education. Thirteen nurses (6.6%) had graduated from a four year baccalaureate degree program in nursing and six nurses (3.1%) had completed a post-diploma baccalaureate degree program in nursing. Four of the respondents did not answer this question.

Table 2

Highest Nursing Education Levels

Education Level	Frequency	Percent
2 year diploma	82	41.8
3 year diploma	87	44.4
Post-basic baccalaureate degree	6	3.1
4 year baccalaureate degree	13	6.6
Masters degree	1	0.5
Other	3	1.5
Missing data	4	2.0
Total	196	99.9

Respondents were equally distributed amongst medical, surgical or combined medical/surgical units (32.7%, 35.2%, 30.1% respectively). Two respondents did not indicate the type of unit they worked on. The number of years respondents practiced nursing ranged from 1 to 40 years (see Table 3). The mean number of years worked as a practicing nurse was 12.7 years ($SD = 8.95$), the median being 10 years. The majority of respondents had been practicing nurses for 10 years or less (55.1%). Forty-three percent of the total sample worked in nursing for more than 10 years.

Table 3

Years of Nursing Experience

Years	Frequency	Percent
1 - 5	44	22.4
6 - 10	64	32.7
11 - 15	18	9.2
16 - 20	27	13.8
21 - 25	24	12.3
26 - 30	6	3.0
31 and over	10	5.0
Missing data	3	1.5
Total	196	99.9

The number of years worked in medical/surgical areas for these respondents ranged from 1 to 38 (see Table 4). The mean number of years worked as a nurse in medical/surgical nursing was 10.9 years ($SD = 7.64$), the median being 8.0 years. The majority (60.8%) of the respondents have worked in medical/surgical nursing for 10 years or less. Those nurses working 10 years or longer in medicine and/or surgery constituted 37.4% of the total sample.

Table 4

Years Worked in Medical/Surgical Nursing

Years Worked	Frequency	Percent
1 - 5	53	27.1
6 - 10	66	33.7
11 -15	27	13.9
16 - 20	21	10.8
21 - 25	16	8.2
26 - 30	4	2.0
31 and over	5	2.5
Missing data	4	2.0
Total	196	100.2

Respondents worked in hospitals ranging in size from 8 to 1100 beds (see Table 5). Almost one-half of the respondents (45.8%) working in hospitals with a bed size of between 100 and 400. Nurses who worked in hospitals with 500 or more beds comprised the next largest group (20.4% of this sample).

Table 5

Hospital Bed Size

Number of Beds	Frequency	Percent
Less than 50	15	7.7
50 - 99	14	7.1
100 - 199	23	11.7
200 - 299	34	17.3
300 - 399	33	16.8
400 - 499	12	6.1
500 - 1100	40	20.4
Missing data	25	12.8
Total	196	99.9

Most respondents, 182 (92.9%), provided the location of their hospital on the demographic form. The 38 different locations reported were coded into two categories, urban and rural. One hundred and three respondents worked in rural areas and 79 respondents worked in urban areas.

Findings

In the following section, findings related to the five research questions posed in this study are presented. Narrative responses to question 27 are discussed and summarized.

Research Question 1: Frequency of Ethical Issues Nurses Encounter

Descriptive statistics were used to analyze the responses to the statements related to how frequently nurses encountered the ethical issues presented. Nurses responded to each statement by using a five-point Likert scale, ranging from 0 = "never" to 4 = "very frequently." The reported frequency distributions, as well as the means and standard deviations for each issue can be found in Table 6. The overall frequency with which ethical issues were encountered was determined by averaging the frequency scores for the 26 issues. The overall mean was 1.09, with a median of 1.08 and a standard deviation of 0.46. These findings indicate that in general nurses believed that they encountered few ethical issues in the past year. The average frequency with which particular issues were encountered ranged from 0.27 to 2.40.

Nurses ranked unsafe staffing patterns as the most frequently encountered ethical issue with a mean of 2.40 (SD = 1.12). The next four most frequently occurring ethical issues encountered related to family demands for futile treatment for the patient (M = 1.97, SD = 1.03), the prolongation of life when death was inevitable (M = 1.76, SD = 1.07), working with a nurse who regularly behaved irresponsibly (M = 1.58, SD = 1.01), and disagreeing with a physician over patient care (M = 1.57, SD = 0.90).

Nurses indicated that the five least frequently encountered issues were knowing that a colleague was affected by substance abuse (M = 0.27, SD = 0.57), being aware of the illegal activity of a nursing colleague (M = 0.33, SD = 0.61), being asked to violate one's personal values (M = 0.36, SD = 0.73), knowing that a family was seeking power of attorney (M = 0.36, SD = 0.62), and being aware of unreported incidents of patient abuse (M = 0.39, SD = 0.75).

Table 6

Frequency of Ethical Issues Nurses Encountered

n = 196

Variable	Mean*	Standard Deviation	Valid N	Label
Q1A	1.286	0.945	196	F:Colleague failed to report an error
Q2A	0.959	0.849	195	F:Faced a decision re: reporting a colleague
Q3A	0.270	0.567	196	F:Knowing a colleague is affected by substance abuse
Q4A	0.769	1.002	195	F:Asked to participate in a slow/partial code
Q5A	0.364	0.622	195	F:Family seeking power of attorney
Q6A	1.260	0.933	196	F:Colleague failed to report an error of omission
Q7A	0.332	0.605	196	F:Aware of a colleague's illegal activity
Q8A	1.487	1.007	195	F:Knowing prognosis/information is being withheld
Q9A	0.847	0.975	196	F:Aware confidentiality of patient records is violated
Q10A	2.403	1.117	196	F:Faced with unsafe staffing patterns
Q11A	1.572	0.898	194	F:Disagreeing with a physician re: patient care
Q12A	1.469	1.010	196	F:Knowing a patient consented without understanding
Q13A	1.510	0.990	196	F:Patient has incomplete info re: procedure
Q14A	1.492	1.150	195	F:Working with inadequate/outdated equipment
Q15A	1.969	1.028	194	F:Family demands for futile treatment for the patient
Q16A	1.577	1.007	196	F:Working with a nurse who behaves irresponsibly
Q17A	0.388	0.746	196	F:Aware of unreported incidents of patient abuse
Q18A	1.755	1.072	196	F:Patient's life is prolonged but death is inevitable
Q19A	1.010	0.942	195	F:Patient is receiving treatment despite objection
Q20A	0.434	0.680	196	F:Family convincing patient to refuse treatment
Q21A	0.362	0.728	196	F:Nurse asked to violate personal values
Q22A	1.071	1.060	196	F:Knowing confidential patient matters are made public
Q23A	1.219	0.943	196	F:Working with a physician with inadequate skills
Q24A	0.791	0.855	196	F:Working in a clinical setting without proper skills
Q25A	0.556	0.732	196	F:Aware a patient is being restrained unnecessarily
Q26A	1.164	1.455	189	F:Not being consulted about personal ethical conflicts

* Scale has a range from 0-4

Research Question 2: The Extent to Which Nurses are Disturbed by Ethical Issues

Descriptive statistics were used to analyze the responses concerning how disturbed nurses became or would have become if they had encountered the 26 ethical issues. Nurses were asked to respond to each of these statements using a Likert scale. Issues were rated as: 0 = "not at all" disturbed, 1 = "a little" disturbed, 2 = "somewhat" disturbed, 3 = "quite a bit" disturbed, and 4 = "a great deal" disturbed. The average level of disturbance experiences for each of the 26 statements ranged from 2.00 to 3.41 (see Table 7). The overall mean was determined by averaging the disturbance scores for all items. The resulting mean was 2.69 (SD = 0.82), with a median of 2.92. These scores indicate that for all of the questions, nurses were at least "somewhat" disturbed about the ethical issues they encountered or would have become so if they had encountered these situations in the practice setting.

The three issues that nurses found most disturbing were working with physicians who demonstrated inadequate knowledge and skills (M = 3.41, SD = 1.10), being faced with unsafe staffing patterns (M = 3.36, SD = 0.95), and the prolongation of patient life when death was inevitable (M = 3.18, SD = 1.11). Nurses indicated that, on average, they were "quite a bit" disturbed by these three ethical issues. Nurses were also disturbed about issues such as caring for a patient whose family was demanding futile treatment (M = 2.96, SD = 1.08), and knowing that information about prognosis was being withheld from a patient and/or family (M = 2.91, SD = 1.25). The five ethical issues that nurses found the least disturbing were being asked to violate one's personal values (M = 2.00, SD = 1.59), having a colleague fail to report a medication error (M = 2.11, SD = 1.20), knowing a colleague failed to report an error of omission

Table 7

Degree of Disturbance Related to Ethical Issues

n = 196

Variable	Mean*	Standard Deviation	Valid N	Label
Q1B	2.108	1.197	185	D:Colleague failed to report an error
Q2B	2.774	1.277	177	D:Faced a decision re: reporting a colleague
Q3B	2.780	1.679	159	D:Knowing a colleague is affected by substance abuse
Q4B	2.431	1.573	167	D:Asked to participate in a slow/partial code
Q5B	2.654	1.595	159	D:Family seeking power of attorney
Q6B	2.160	1.170	181	D:Colleague failed to report an error of omission
Q7B	2.369	1.673	157	D:Aware of a colleague's illegal activity
Q8B	2.909	1.247	186	D:Knowing prognosis/information is being withheld
Q9B	2.649	1.303	174	D:Aware confidentiality of patient records is violated
Q10B	3.361	0.946	191	D:Faced with unsafe staffing patterns
Q11B	2.817	1.129	186	D:Disagreeing with a physician re: patient care
Q12B	2.715	1.212	186	D:Knowing a patient consented without understanding
Q13B	2.656	1.122	189	D:Patient has incomplete info re: procedure
Q14B	2.530	1.289	181	D:Working with inadequate/outdated equipment
Q15B	2.962	1.079	182	D:Family demands for futile treatment for the patient
Q16B	2.683	1.162	183	D:Working with a nurse who behaves irresponsibly
Q17B	2.752	1.688	161	D:Aware of unreported incidents of patient abuse
Q18B	3.176	1.112	188	D:Patient's life is prolonged but death is inevitable
Q19B	2.876	1.313	177	D:Patient is receiving treatment despite objection
Q20B	2.458	1.504	166	D:Family convincing patient to refuse treatment
Q21B	2.000	1.593	165	D:Nurse asked to violate personal values
Q22B	2.657	1.349	178	D:Knowing confidential patient matters are made public
Q23B	3.413	1.103	184	D:Working with a physician with inadequate skills
Q24B	2.626	1.499	171	D:Working in a clinical setting without proper skills
Q25B	2.337	1.436	160	D:Aware a patient is being restrained unnecessarily
Q26B	2.161	1.457	168	D:Not being consulted about personal ethical conflicts

* Scale has a range from 0-4

(\underline{M} = 2.16, \underline{SD} = 1.17), not being consulted about personal ethical conflicts (\underline{M} = 2.16, \underline{SD} = 1.46), and being aware that a patient is restrained unnecessarily (\underline{M} = 2.34, \underline{SD} = 1.44).

Additional Ethical Issues Faced in the Past Year

Respondents were also asked to describe any ethical issues they had faced in the past year which had not been included in the 26 items listed in the questionnaire. Fifty six nurses (29%) described one or more ethical issues they had encountered in their practice setting. Of those who responded to this question, 21 respondents also wrote additional comments in the margins of the questionnaire. Of those not responding to question 27, 15 respondents wrote comments throughout the questionnaire.

Responses to question 27 were grouped into a number of categories as shown in Table 8. Only issues reported by more than one nurse are included in the table. Issues are listed in order of frequency. The three ethical situations mentioned most frequently were those concerned with active euthanasia, Do Not Resuscitate (DNR) orders, and the withholding of medical interventions deemed necessary by the respondent.

Table 8

Additional Ethical Issues Faced in the Past Year

n = 56

Nature of the Comment	Number of Respondents
Active euthanasia	6
Issues related to DNR Orders	6
Withholding of medical interventions deemed necessary	6
Inappropriate use of hospital beds	4
Inappropriate health care for the elderly	4
Safety of staffing levels and patterns	4
Informed consent	3
Physician/nurse relationships	3
Non-accessibility/non-responsiveness of physicians	3
Intervening against patients' wishes	3
Physician incompetence and unethical conduct	3
Inappropriate pain relief	2
Patient Care Associates	2
Family interference in care of a competent patient	2
Patient abuse against nurses	2
Negative consequences of reporting ethical dilemmas	2
Nursing team relationships	2
Prolongation of life when futile	2
Physician over billing Medical Services Plan	2
Total	61*

* Responses total 61 as some respondents gave more than one answer.

Six nurses identified active euthanasia as a significant ethical issue. One nurse described the following situation: "A family requested that I call a doctor to provide - or give myself - medication to end a life." A similar comment described circumstances in which the nurse was asked by the family or patient to administer an injection that would

end the patient's life. A third nurse made the following related comment: "It has often been suggested by the family, or sometimes other nurses and occasionally doctors, to 'speed things up' for a dying, palliative care patient." Another ethical issue nurses reported concerned DNR orders. One nurse expressed several concerns about DNR orders, including physicians' refusal to write DNR orders on patients who are terminally ill or to discuss such an order with a patient or family.

The withholding of a medical intervention that was deemed necessary by the respondent was identified as an ethical issue by six nurses. For one nurse, this ethical problem was posed when physicians did not send critically ill patients to larger, better equipped hospitals. Another nurse described an instance where a patient required a consultation and the physician was unwilling to request one. A third nurse discussed cases when patients requested a second medical opinion and their physicians discouraged them from obtaining one. Additional specific ethical issues, which at least four nurses identified, included the inappropriate use of hospital beds, inappropriate health care for the elderly, and unsafe staffing levels and patterns. Arising from new developments in health care are issues related to Patient Care Associates (PCA's) (identified by two nurses), and physician over-billing of the Medical Services Plan (identified by two nurses).

Eighteen percent of the respondents added comments along the margins of the questionnaire. Every question on the tool was commented on by at least one nurse. Numbers of "written in" comments ranged from 1 to 12. Questions 1, 4, 6, 8, 12 and 13 received the largest number of comments. Twelve nurses commented on question one which stated, "You know that a nursing colleague has failed to report a medication

error." Eleven indicated that whether or not they would report this incident depended on the "severity of the error" or the "magnitude of the error." Question six, "You know that a nursing colleague has failed to report an error of omission," produced similar comments. Of the 12 comments on this question, eight qualified that reporting "depends on the importance of the drug or treatment." Nurses also responded emphatically to question four regarding a direction to participate in a "slow code" or "partial code". Although some of the nurses wrote specific examples they had experienced, five stated that participation "depended on the situation" or that it depended "on the age of the patient and surrounding circumstances." In response to question eight, "You know information about prognosis is being withheld from the patient and/or family," nurses also wrote similar comments such as "it would depend on the information and circumstances." For questions 12 and 13 regarding patients' understanding and consent to treatment, nurses tended to provide examples of their values and experiences. Although they wrote comments about all of the questions, many nurses wrote brief examples of situations they had encountered in their practice setting. For example, one nurse made the following comment:

Just recently, a colleague altered her charting and another nurse's charting to cover up a drug overdose. Thankfully, with encouragement, the younger nurse reported the error, but not the alteration made by her older colleague who did the altering. That is tough.

Another nurse stated:

Over the past year, one of our surgeons had numerous patient complications as well as a couple deaths. He has a serious heart condition and is of, or beyond,

retirement age. It was very difficult caring for his patients, who had come for elective surgery, when I felt they had little or no understanding of the risk they were facing...

Three nurses wrote comments to indicate how angry, frustrated, and powerless ethical issues made them feel. One nurse stated, "My biggest concern is the constant and continuing increase in the amount and complexity of the workload we have to contend with, and the powerlessness we feel to do anything about the unsafe situation." Another nurse expressed concerns about the difficulties she faced in her workplace:

I went through an actual experience where a colleague was using drugs on the job and a few of us reported her and had to go through subsequent trials....This was by far the hardest, most difficult experience in my nursing career.

From another nurse:

I work on a CTU with some resident physicians who refuse to consult when their knowledge or skills are inadequate. We have had two incidents in the past three weeks where nurses are "begging" residents for intensive care unit (ICU) consults and nurses' requests are shrugged off. Both patients coded and one expired on the same shift that the requests were made. Extremely frustrating and unnecessary.

In summary, 36% of respondents either identified additional ethical issues or wrote comments on the margins of the questionnaire. The specific examples of ethical issues provided by these nurses offer valuable insight into some of the concerns nurses are facing at the bedside. Findings of the Likert scale questions were augmented by narrative answers to question 27 and "written in" comments.

Research Question 3: Nurses' Use of Codes of Ethics and Standards of Practice

Nurses were asked if they possessed and referred to their code of ethics and standards of practice. One hundred and twenty-eight (65.3%) of the nurses in this study indicated they possessed a copy of the Canadian Nurses Association Code of Ethics. However, only 35 (17.9%) of the respondents indicated that they had referred to their code of ethics in the past year. By comparison, 162 (82.7%) of the respondents were familiar with their RNABC Standards for Nursing Practice and 89 (45.4%) indicated that they had referred to their standards of practice in the past year. Eight nurses did not respond to question three.

Research Question 4: Resources Used by Nurses

Descriptive statistics were used to analyze the responses that nurses used in the past year to resolve ethical issues (see Table 9). Most nurses (93.2%) consulted nursing colleagues as a resource when trying to resolve ethical issues. Head Nurses were also used as a resource by 170 (89.5%) of the respondents, followed by physicians, family members, and social workers. Nurses who responded to the 'other' category reported using resources such as patients, friends, the clergy, the chief of staff (medicine), psychiatrists, psychologists, and legal counsel.

Table 9

Resources Used by Nurses to Resolve Ethical Issues n=196

Resources	Number of Responses	Percent
Nursing colleagues	177	93.2
Head/Nurse/Nurse Manager	170	89.5
Physician	121	63.7
Family members	116	61.1
Social Worker	98	51.6
Clinical Nurse Specialist	67	35.3
Literature	51	26.8
Hospital Chaplain	45	23.7
Director of Nursing	30	15.8
Nursing instructor	30	15.8
Educational sessions regarding ethics	19	10.0
Other	17	8.9
Nursing ethics rounds	11	5.8
Nursing Consultant	4	2.1

Research Question 5: Relationship Between Demographic Variables and Nurses' Experience With Specific Ethical Issues

Since nurses were asked to respond to 26 ethical statements for each of the two Subscales (Frequency and Disturbed), the investigator decided that it would be more useful to examine the relationships between the five most frequent and the five most disturbing ethical issues, and the selected demographics. Relationships between the five most frequent and the five most disturbing ethical issues, and years practiced as a nurse, years worked in medical/surgical nursing, age of the nurse and hospital bed size were assessed using Pearson's Product-Moment Correlation Coefficient (see Table 10).

Although most of the associations between the variables are weak, the findings suggest that the longer nurses practice, and the longer they work in medical/surgical nursing, the

less frequently they report encountering these particular ethical issues. Significant negative weak relationships between age and the frequency of encountering four of the five ethical issues were also demonstrated. The frequency of encountering unsafe staffing patterns was unrelated to a nurse's age. None of the five most frequently occurring ethical issues related to hospital bed size.

Four significant negative weak relationships were identified between the five most disturbing ethical issues and specific demographic variables. First, it was found that an inverse relationship exists between the nurse's age and the ethical issue presented in statement 23 which refers to working with physicians who demonstrated inadequate knowledge and skills. Second, a negative relationship was also found between the length of time nurses practiced, the number of years nurses worked in medical/surgical nursing and the nurse's age, and their level of disturbance related to ethical situations where nurses are aware that information regarding prognosis is being withheld from the patient and/or family.

A Hotelling's t test was used to determine if there was a difference between the five most frequent and the five most disturbing ethical issues, and level of nurses' education and hospital location. The Hotelling's is a t test, modified so that it can be used to look at two or more dependent variables at the same time (Norman & Streiner, 1986). In order to conduct a Hotelling's t test, the five levels of nursing education were collapsed into two groups (diploma or degree). The findings indicate that the profile of the top frequency scores does not depend on whether the nurse's education is either a diploma or a degree ($p = 0.94$). There was also no significant difference between degree and diploma education with respect to the top five disturbance scores ($p = 0.34$).

Table 10

Correlations Between Frequency and Disturbance Items, and Years Practiced as a Nurse, Years Worked in Medical/Surgical Nursing, Age, and Hospital Bed Size

		YEARS PRACTICED AS A NURSE	YEARS WORKED IN MEDICAL/SURGICAL NURSING	AGE	HOSPITAL BED SIZE
Most Frequently Occurring Issues:					
10A	Unsafe staffing patterns	-.16*	-.13*	-.08	-.02
15A	Family demanding futile treatment	-.19**	-.17**	-.24***	.03
18A	Prolonging life with heroic measures	-.20**	-.16*	-.18**	.003
16A	Nurse who behaves irresponsibly	-.16*	-.16*	-.13*	.13
11A	Physician/nurse conflict regarding patient care	-.15*	-.16*	-.18**	-.07
Most Disturbing Issues:					
23B	Incompetent physician	-.04	-.02	-.13*	-.001
10B	Unsafe staffing patterns	-.09	-.02	-.10	-.005
18B	Prolonging life with heroic measures	-.03	-.05	-.06	-.10
15B	Family demanding futile treatment	-.04	-.06	-.10	.05
8B	Withholding information regarding prognosis	-.19**	-.20**	-.22**	.02
* p < .05 ** p < .01 *** p < .001					

No significant difference was found between urban and rural hospital location with respect to either the top five frequency items ($p = 0.41$) or disturbance items ($p = 0.56$).

Multivariate Analysis of Variance (MANOVA) was used to determine if there was an association between the independent variables, types of units where nurses worked, and the dependent variables, scores on the five most frequent and five most disturbing ethical issues. A significant difference ($p < 0.01$) was found between the units and the top five frequency items. Further investigation using univariate Analysis of Variances (ANOVA) revealed a highly significant difference between the units on the Frequency Subscale of statement 15 (caring for a patient whose family is demanding futile treatment) [$F(2, 185) = 7.39$; $p = < 0.001$], and marginally statistically significant differences between units on the Frequency Subscale of statement 18 (prolonging a patient's life when death is inevitable) [$F(2, 185) = 3.62$; $p = < 0.028$], and statement 11 (physician/nurse conflict regarding patient care) [$F(2, 185) = 4.56$; $p = < 0.012$]. Fisher's Least Significant Difference (LSD) was then performed to determine exactly which of the units were different on these three statements. The findings suggest that the differences were due to nurses working on surgical units having lower frequency scores ($p < 0.05$) on these items than those working on either medical or combined medical/surgical units. In addition, the nurses working on medical and combined medical/surgical units were not significantly different. For example, on statement 15 (caring for a patient whose family is demanding futile treatment), the mean frequency for nurses working on a surgical unit is 1.64, compared with means of 2.30 for those working on medical units and 2.02 for those on combined medical/surgical units (see Table 11). Therefore, nurses working on surgical units encounter issues related to

families demanding futile treatment, prolonging a patient's life with heroic measures, and physician/nurse conflict regarding patient care less frequently than nurses working on medical or combined medical/surgical units. There was no significant difference between any of the three nursing units and the top five disturbance items ($p=0.15$).

Summary of Findings

A sample of 196 registered medical/surgical staff nurses who worked full-time in hospitals throughout British Columbia participated in this study. Two hundred and two questionnaires were returned for a response rate of 50.5%, with 49% used in the statistical analysis. Demographic information collected from the respondents included: age, gender, highest level of nursing education, area of current employment, number of years of nursing experience, number of years worked on medical and/or surgical nursing units, hospital bed size, and hospital location.

Descriptive statistics were used to answer the first research question that asked how frequently nurses encountered ethical issues. The five most frequently encountered ethical issues that nurses reported were: (1) unsafe staffing patterns, (2) caring for a patient whose family was demanding futile treatment, (3) the prolongation of a patient's life when death was inevitable, (4) working with a nurse who regularly behaved irresponsibly, and (5) disagreeing with a physician over patient care.

Descriptive statistics were also used to answer the second research question that asked how disturbed nurses became or would become if they encountered these specific ethical issues. The five most disturbing issues that nurses reported were: (1) working with physicians who demonstrated inadequate knowledge and skills, (2) being faced with unsafe staffing patterns, (3) the prolongation of a patient's life when death was

Table 11

Means and Standard Deviations for the Five Most Frequent and the Five Most Disturbing Ethical Issues with Respect to the Three Types of Units Where Respondents Worked

		UNIT	N	MEAN	SD
Most Frequently Occurring Issues:					
10A	Unsafe staffing patterns	Medical	64	2.34	1.21
		Surgical	69	2.36	1.10
		Combined	59	2.49	1.06
15A	Family demanding futile treatment	Medical	64	2.30	0.89
		Surgical	67	1.64	1.12
		Combined	59	2.02	0.96
18A	Prolonging life with heroic measures	Medical	64	1.97	1.08
		Surgical	69	1.45	1.09
		Combined	59	1.85	1.00
16A	Nurse who behaves irresponsibly	Medical	64	1.55	0.91
		Surgical	69	1.51	1.02
		Combined	59	1.64	1.08
11A	Physician/nurse conflict regarding patient care	Medical	64	1.81	0.85
		Surgical	68	1.34	0.86
		Combined	58	1.60	0.94
Most Disturbing Issues:					
23B	Incompetent physician	Medical	63	3.60	0.79
		Surgical	65	3.06	1.43
		Combined	52	3.60	0.87
10B	Unsafe staffing patterns	Medical	62	3.29	1.11
		Surgical	68	3.37	0.84
		Combined	57	3.44	0.89
18B	Prolonging life with heroic measures	Medical	63	3.21	1.15
		Surgical	65	3.08	1.29
		Combined	56	3.21	0.85
15B	Family demanding futile treatment	Medical	63	3.13	0.98
		Surgical	60	2.92	1.14
		Combined	55	2.89	1.07
8B	Withholding information regarding prognosis	Medical	62	2.97	1.24
		Surgical	65	2.69	1.40
		Combined	56	3.07	1.06

inevitable, (4) caring for a patient whose family was demanding futile treatment, and (5) knowing that information about prognosis was being withheld from the patient and/or family.

Fifty-six nurses (29%) identified additional ethical issues encountered in the past year. The three additional ethical situations mentioned most often were those concerned with active euthanasia, DNR orders, and the withholding of medical interventions deemed necessary by the respondents.

The findings of this study indicated that 65.3% of the study sample possessed a copy of the Canadian Nurses Association Code of Ethics. However, only 17.9% of the respondents indicated that they had referred to this code of ethics in the past year. By comparison, 82.7% of the respondents were familiar with the RNABC Standards for Nursing Practice, with 45.4% indicating that they had referred to them in the past year.

When trying to resolve ethical issues most nurses consulted nursing colleagues (93.2%) or their head nurse (89.5%). Respondents also reported frequently consulting with physicians, family members, and social workers.

Pearson's Product-Moment Correlation Coefficients were used to determine if there was a relationship between the five most frequent and the five most disturbing ethical issues reported, and the number of years practiced as a nurse, the number of years in medical/surgical nursing, the age of the nurse, and the bed size of the hospital in which she or he was employed. The findings suggest that the longer nurses practiced and the longer they work in medical/surgical nursing, the less frequently they reportedly encountered the five top ethical issues. Significant but weak negative relationships between the nurses' age and the frequency of encountering four of the five ethical issues

were also identified.

Four significant but weak negative relationships were identified between the five most disturbing ethical issues and select demographics. First, it was found that the older nurses get, the less disturbed they reported being about the issues related to incompetent physicians, and knowing that information regarding prognosis is being withheld from the patient and/or family. Second, the findings suggest that the longer nurses practice and the longer nurses work in medical/surgical nursing the less disturbed they are about knowing that information regarding prognosis is being withheld from the patient and/or family.

Hotelling's t test was used to determine if there was difference between the first five most frequent and the five most disturbing ethical issues, and the level of nurses' education and hospital location. The findings revealed that the profile of the top frequency and disturbance scores does not depend on whether the nurse's education is either diploma or degree. No significant difference was found between urban and rural hospital locations with respect to their profile or either the top five frequency or disturbance items.

MANOVA was used to determine if there was a relationship between the five most frequent and the five most disturbing items, and the type of unit where nurses worked. A significant difference was found between the units and the profile of the top five frequency items. These differences occurred in three of the statements. Results of the Fisher's Least Significant Difference test revealed that differences were due to nurses working on surgical units having lower frequency scores on these items than the nurses who worked on either medical or combined medical/surgical units. No significant

difference was found between any of the nursing units and the top five disturbance items.

CHAPTER FIVE: DISCUSSION, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This study was designed to investigate the experiences of nurses working on medical/surgical units in relation to the ethical issues they encounter and how they feel about them. A discussion of the research findings is presented in this chapter; the conclusions, the implications for nursing practice, education, administration, and recommendations for further research follow.

Discussion of Findings

The purpose of this study was to describe the experiences of nurses working on medical/surgical units in relation to ethical situations encountered and their responses to them. Relationships between nurses' experience with specific ethical issues and demographic characteristics of the nurses were also examined.

Eighty-eight percent of the respondents possessed a diploma in nursing, having completed either two or three years of nursing education. Those nurses with a baccalaureate degree in nursing comprised 9.9% of the total sample. In 1991, 8.5% of all British Columbian nurses possessed a baccalaureate degree in nursing (University of British Columbia, Health Human Resources Unit, 1992). Therefore, the educational characteristics of the sample appear to be representative of nurses in this province. The number of respondents were almost equally distributed among medical, surgical, and combined medical/surgical units (33.3%, 35.9%, and 30.7% respectively), and thus, comparisons between these groups can be made.

Respondents who completed the questionnaire were experienced nurses. Nurses

with more than five years experience comprised 76.0% of the sample. Seventy-one percent of the sample had worked for five or more years in medical/surgical nursing. Of the respondents, 45.8% worked in hospitals with a bed size of between 100 and 400.

The findings in this study indicate that, in general, nurses reported that they "rarely" encountered the identified ethical issues. This is consistent with the findings of Berger et al. (1991) who found that nurses "rarely" encountered ethical issues. The findings, however, are inconsistent with other authors who suggest that nurses are facing increasing numbers of ethical issues (Davis, 1988; Erickson, 1993; Holly, 1993), and a wider range and variety of ethical issues (Storch, 1988). Whether this sample of nurses did not experience many ethical issues or whether they did not recognize them in their practice setting is not known. With 24% of the respondents 45 years of age and older, and 86% diploma prepared, the question of whether or not they have received ethical education in their nursing programs is raised. Although data were not collected to determine respondents' educational background with respect to ethics, it is conceivable that nurses who have not had ethics education may be less sensitive to ethical issues.

Three of the five most frequently encountered ethical issues (inadequate staffing patterns, life prolonged with heroic measures, and irresponsible activities of colleagues), were reported by Berger et al. (1991). Other researchers also found that issues related to death and dying were important ethical issues for nurses (Crisham, 1981; Holly, 1993; Miya et al., 1991; Youell, 1986). More specifically, the prolongation of a patient's life using heroic measures has been identified as an ethical issue in several investigations (Davis, 1981, 1988; Fenton, 1987; Rodney, 1987; Wilkinson, 1985). The present study's findings that nurses encounter ethical issues surrounding family demands for futile

treatment for the patient and disagreements with physicians about patient care have not been identified as significant issues by previous researchers.

Although findings from both the present study and Berger et al. (1991) indicate that nurses encountered ethical issues related to inadequate staffing and irresponsible activities of nursing colleagues, this was not specifically identified by previous research. A number of researchers identified the allocation of resources as an ethical issue encountered by nurses (Aroskar, 1989; Crisham, 1981; Sietsema & Spradley, 1987; Youell, 1986), but whether this includes inadequate staffing patterns is difficult to ascertain. Two findings that researchers reported as significant ethical issues in earlier studies, but which were not found to be encountered frequently by nurses in the present study, included the competence of nursing staff (Aroskar; Berger et al., 1991; Davis, 1981; Haddad, 1992; Youell), and nurses' lack of involvement in ethical decision-making about their patients (Erlen & Frost, 1991; Holly, 1989; Martin, 1989; Rodney, 1987).

Overall, nurses reported being at least "somewhat" disturbed about the ethical issues they encountered or would have become so if they had encountered these situations in the practice setting. In fact, nurses were "quite a bit" disturbed by the first three ethical issues reported which were related to working with physicians who demonstrated inadequate knowledge and skills, being faced with unsafe staffing patterns, and prolonging a patient's life when death was inevitable. Nurses were also disturbed by issues such as caring for a patient whose family is demanding futile treatment, and knowing that information about prognosis is being withheld from the patient and/or family.

Three of the five most disturbing issues were those frequently encountered:

unsafe staffing patterns, families demanding futile treatment for the patient, and the prolongation of life with heroic measures. These findings support the work of Berger et al. (1991) who revealed that nurses were disturbed by issues related to inadequate staffing and prolonging life with heroic measures. She also found, however, that nurses were disturbed by situations involving treatment against patients' objections, acting against personal principles and incidents of patient abuse. These differences in findings may be related to the fact that 27% of the respondents were critical care nurses and 21% were administrators. Nurses from other studies also reported that issues related to prolongation of life of their patients were of concern to them (Holly, 1991; Martin, 1990; Miya et al., 1991).

Clearly, urban and rural nurses alike are disturbed about what they perceive to be inadequate staffing patterns encountered in hospital settings throughout British Columbia. Not only was inadequate staffing reported as being the number one issue in the Frequency Subscale and the number two issue in the Disturbed Subscale, but it was also identified by a number of nurses in question 27. Other than the findings of Berger et al. (1991), this ethical issue has not been identified in either the anecdotal literature or recent research studies. British Columbian nurses' concern about this ethical issue may be increasing because of recent hospital and bed closures, the influence of budgetary constraints on staffing patterns, and imminent changes to the health care system in this province.

Additional information gathered from responses to an open-ended question indicated that nurses felt angry, frustrated, and powerless when they encountered specific ethical situations. These feelings were congruent with those reported by nurses in

previous studies (Duncan, 1989; Erlen & Frost, 1991; Martin, 1989, 1991; Wilkinson, 1985). Although the concept of "powerlessness" was not specifically referred to in the questionnaire, the ethical issues nurses identified as being the most frequent and disturbing, as well as those situations nurses described, suggest that they are experiencing feelings of powerlessness. Nurses used expressions such as "begging," "being shrugged off," "not being consulted on any level," and "the powerlessness we feel to do anything." Those feelings of powerlessness may be attributed to an underlying problem related to how much input nurses have into ethical decision-making. Further research that explores the emotional responses to ethical issues nurses encountered in the clinical setting is required.

Nurses used the RNABC Standards for Nursing Practice more frequently than the CNA Code of Ethics in their practice. Only 17.9% indicated that they had referred to their code of ethics when facing an ethical issues, while 47.3% had used their standards of practice. The "Code of Ethics for Nursing" delineates the "obligations of nurses to use their knowledge and skills for the benefit of others, to minimize harm, to respect client autonomy and to provide fair and just care for their clients" (Canadian Nurses Association, 1991, p. ii). It is regrettable that so few nurses refer to this code as it outlines the basic moral commitments of nurses, and provides guidance for nurses facing ethical issues. The RNABC Standards for Nursing Practice (1992), however, are written statements that outline the criteria according to which all registered nurses will be evaluated. "The statements are descriptions of nursing actions and, as a whole, they are intended to describe the practice of nursing" (Registered Nurses Association of British Columbia, 1992, p. 1). One of six standards refers specifically to nursing ethics, outlining

the nurse's responsibility to adhere to the ethical standards of the nursing profession.

RNABC practice consultants use the standards of practice when guiding nurses through the process of resolving problems in the workplace. The RNABC Standards Project may account for the high percentage of nurses who use the standards. In 1992, the RNABC developed and implemented the Standards Project to educate British Columbian registered nurses about their standards of practice, as well as how to use them to resolve problems in the workplace. To educate nurses on use of the standards, the RNABC conducted three hour workshops throughout the province. Since June 1991, 1509 registered nurses have completed this workshop (R. McKay, personal communication, June 27, 1994). Both administrators and staff nurses receive education about the standards of practice. Commencing January 1993, the RNABC also began offering all day workshops that focused on "training the trainer". The 111 nurses who attended the trainer program learned how to teach nurses in their own facility about how to use their standards of practice in the workplace.

Nurses reported they used nursing colleagues, head nurses, physicians, and family members as resources when addressing ethical issues. In response to a similar question, Berger et al. (1991) found that subjects used nursing colleagues and family most frequently as resources. Sietsema and Spradley (1987) also listed nursing colleagues as the third most common resource used by nursing executives in resolving ethical issues. Although the findings of the present study identify the resources medical/surgical nurses use in resolving ethical issues, it can not be determined from the data what resources nurses need and what resources are available to nurses in their hospital. Since 85% of the respondents worked in hospitals with at least 100 beds, it is possible that other

resources such as ethics committees may have been available to them. However, even if nurses have the resources available to them in their hospitals, are they actually able or know how to use them? Further, do administrators and other health care providers (eg. physicians) impede staff nurses from accessing the resources they need to participate in and resolve ethical issues? Storch and Griener (1992) found that few nurses were aware of the presence of ethics committees in their hospitals. In addition, in one of the five hospitals, 61% of the nurses surveyed were not aware of any ethical education being offered by the hospital, even though ethical programs were being offered.

Although a weak association exists between the five most frequently encountered ethical issues, and years practiced as a nurse and years worked in medical/surgical nursing, conclusions can still be drawn from these results. These findings suggest that the longer the nurses practice, and the longer they work in medical/surgical nursing, the less frequently they report encountering ethical issues of unsafe staffing patterns, family demanding futile treatment, working with a nurse who behaves irresponsibly and physician/nurse conflicts regarding patient care. A significant weak relationship exists between age and the frequency of encountering four of the five ethical issues. It is possible that older, more experienced nurses encounter these ethical issues less frequently than younger nurses because of their educational background. Older nurses may not recognize particular ethical issues because they have not received education on ethics in their nursing diploma programs. It is also possible that frequent exposure to these issues over time with the development of habitual patterns of coping has decreased their sensitivity to them. These findings, however, should be interpreted with caution because of the inconsistent patterns of results in the literature. While Berger et al.

(1991) found no relationship between age or experience and the frequency of issues reported, Davis (1981) found that age was related to frequency with which dilemmas occur in different interactions for nurses who worked in acute care, operating room, inpatient and outpatient departments, community and non-traditional facilities. Davis stated that a "significant positive correlations between age group and infrequency of ethical dilemmas were found for dilemmas related to interaction with patients, families, physicians, and the institution" (p. 403).

A significant relationship was also identified between the type of unit on which nurses work and the five most frequently encountered ethical issues. The findings suggest that nurses working on surgical units encounter issues related to families demanding futile treatment, prolonging life with heroic measures, and physician/nurse conflict regarding patient care less frequently than do nurses working on medical or combined medical/surgical units. This may be due to the fact that many patients on medical units are elderly and suffer from long term chronic illnesses. Situations involving issues such as DNR orders, prolongation of life, and family demanding futile treatment are understandably common. In contrast, patients admitted to surgical wards frequently have shorter hospital stays and a different profile. This finding would suggest that nurses working on medical units or combined medical/surgical units may need more ethics education and psychological support to deal with the ethical issues encountered.

This researcher was gratified to note that 71 (36%) nurses took the time to answer question 27, as well as to add hand written comments along the margins of the questionnaire. This indicates that the questions were thought-provoking, and that the nurses cared enough about the topic to provide more information than was asked of

them. In some cases, respondents provided three or four examples of ethical issues.

The three most frequently identified additional ethical issues were those related to active euthanasia, DNR orders, and withholding of medical interventions which the nurse deemed necessary. Nurses described situations where they were asked by patients, family members and physicians to give medications to patients in order to speed up the dying process. Although many experts have written about the issue of euthanasia (Bandman & Bandman, 1990; Beauchamp & Childress, 1989; Beauchamp & Walters, 1982; Davis & Aroskar, 1983; Storch, 1982; Tschudin, 1992; Veatch & Fry, 1987), this has not been identified as an ethical issue in previous research. Martin (1991) however, reported in a study of 75 registered nurses that the most problematic issues for nurses involved patients asking them for assistance in committing suicide; but since she does not define "assisted suicide," it may not be synonymous with "euthanasia". Active euthanasia is the "act of directly killing a person for reasons of mercy" (Special Advisory Committee on Ethical Issues in Health Care, 1994, p. 1). Whereas the phrase "assisted suicide" refers to situations in which a health care professional assists a patient, directly or indirectly, to take his or her own life. The main difference between these two terms is that in active euthanasia another person, for example, a health care professional is the direct cause of the patient's death and in assisted suicide another person assists the patient in causing his or her own death. Because, questions about euthanasia were not included in the present study, they must be included in future revisions of the tool since patients' rights related to euthanasia are becoming an issue of great concern to society. Future research needs to explore in more depth the context of both assisted suicide and euthanasia.

The nursing and medical community need to talk openly about active euthanasia for a number of reasons. First, it offers each discipline the opportunity to understand other perspectives on active euthanasia and specific experiences individual professionals have encountered. Second, through collaboration, mutual decision-making can commence. Third, open dialogue may create an environment whereby health care professionals can express their concerns and feelings. Fourth, in order to determine the magnitude of the issue, or the number of requests related to active euthanasia, the nursing and medical community need to discuss each case.

Nurses also identified concerns about ethical issues related to Do Not Resuscitate (DNR) orders. The questionnaire included only one statement about resuscitation orders: "your patient has unclarified code orders and you are asked to participate in a slow code or partial code." This statement does not address situations where physicians refuse to write code orders or fail to obtain input from patients or family members about code status. Subjects who described DNR orders indicated concern about these broader issues. Findings by Aroskar (1989) and Martin (1991) also indicated that DNR orders posed significant ethical problems for nurses. Further revisions to this tool should both expand the number of questions about DNR orders and increase their specificity.

Six nurses also identified the withholding of medical intervention which the nurse deemed necessary as an ethical issue. Previous studies have not identified this as an ethical issue for nurses, and it is also not commonly discussed by many experts in nursing ethics (Benjamin & Curtis, 1992; Kelly, 1991; Storch, 1988; White, 1992). Further research should explore changing relationships and decision-making models between doctors, nurses and patients.

Additional specific ethical issues identified by nurses included the inappropriate use of hospital beds, inappropriate health care to the elderly (over and under treatment), lack of safety in staffing levels and patterns, and problems related to informed consent. A number of concerns not identified in previous research were also reported. These related to "Patient Care Associates" (a new category of health care worker), negative consequences of reporting ethical dilemmas, and physician overcharging the Medical Services Plan (MSP). According to one nurse:

The introduction of PCA's has introduced many, many conflicts in this hospital. To have someone with four hours training, who worked at Kentucky Fried Chicken last week and is now doing peri care, or assisting with transfers of patients with very complex problems....We have had PCAs disconnect tubes...without the nurse being aware...and without the PCA having any knowledge of what the tubes are for.

Ethical issues not identified in previous research, such as those related to PCA's and physician overcharging of MSP, need to be explored further to determine nurses' concerns when they encounter these issues in the workplace.

Eighteen percent of respondents added comments along the margins of the tool. Every question on the tool was commented on by at least one nurse. Davis (1981) also found that nurses wrote numerous and often lengthy comments on the back of the questionnaire. Comments were made to questions such as "depends on the severity of the error," "depends on the importance of the drug or treatment," and "depends on the age of the patient and surrounding circumstances." These comments may indicate that some questions need to be reworded for increased clarity or expanded to explore nurses'

use of judgement when faced with ethical issues.

Although the original instrument (SEIN) developed by Jacobs and Severson (1989) was revised by this investigator, and with input from content experts, a number of apparent limitations in the tool emerged as a result of this study. First, it was evident from the written responses to question 27 which asked nurses to describe any ethical issues in the past year not discussed in the questionnaire, that there were some key ethical issues that should be either included or expanded in number in section one of the SEIN-R. For example, additional questions related to active euthanasia, DNR orders, and the withholding of medical interventions nurses deemed necessary need to be included in section one. Second, further consideration must be given to the ordering of the ethical statements presented in section one. Both the ordering and number of statements related to nursing competence may evoke a negative response from respondents, and thus result in a lower response rate.

Third, the findings indicated that a number of respondents did not answer some of the items for the Disturbed Subscale (see Table 4). For example, only 165 nurses (84%) responded to question 21B which related to nurses being asked to practice nursing in a way that violates their personal values. Another 168 nurses (86%) only responded to statement 26B which related to nurses' not being consulted about their personal ethical conflicts related to the care they are required to give. These response rates are relatively low in comparison to response rates for other items in the survey and may indicate that the non-respondents did not understand or know how to answer these questions. Therefore, items that elicited low response rates for the Disturbed Subscale must be examined for their clarity and the overall instructions may require revision.

Lastly, although it could be determined from the SEIN-R what resources nurses used to resolve ethical issues, it could not be ascertained from these results, the resources that nurses want or need in helping them to work through difficult ethical issues. Knowledge about the resources nurses need when faced with ethical issues would have strengthened the results of this research. Therefore, given some of the limitations presented throughout the discussion section, the SEIN-R should be used with caution and if used in future research further revision of this tool is recommended.

Conclusions

Findings of this study lend partial support to results of other research which describe nurses' experiences in relation to the ethical situations they encounter. The following conclusions must be interpreted with caution when generalizing to other nurses, particularly those who work in areas other than medical/surgical units and in other institutions outside the Canadian health care context.

- 1) Overall, nurses report encountering ethical issues "rarely." The two most frequently occurring ethical issues are unsafe staffing patterns and family demands for futile treatment for the patient.
- 2) Overall, nurses are at least "somewhat" disturbed by the ethical issues they encounter in the workplace. Nurses are "quite a bit" disturbed about the issues relating to working with physicians who demonstrate inadequate knowledge and skills, unsafe staffing patterns, and prolongation of a patient's life when death is inevitable.
- 3) The longer nurses practice and the longer they work in medical/surgical nursing, the less frequently they report encountering ethical issues.
- 4) Nurses working on surgical units report encountering ethical issues related to

families demanding futile treatment, prolonging life with heroic measures, and physician/nurse conflict regarding patient care less frequently, than do nurses working on medical or combined medical/surgical units.

5) Nurses report that they do not rely heavily on their codes of ethics to resolve ethical dilemmas. Nurses more frequently use standards of practice as a resource. Additional resources used are nursing colleagues, head nurses, physicians, and family members.

6) Active euthanasia, DNR orders, and withholding of medical intervention deemed necessary appear to be significant ethical situations for nurses not included in the SEIN - R.

Implications

The findings of this study suggest many implications for nurses facing ethical issues in their clinical settings. Implications for nursing practice, education and administration are presented in the following sections.

Nursing Practice

Nurses may face increasingly difficult and complex ethical issues in the practice setting because of significant changes occurring in British Columbia's health care system. Ethical issues that have been documented both empirically and anecdotally such as allocation of resources, competence of nursing staff, and issues related to death and dying will continue to pose ethical dilemmas for nurses. This research indicates, however, that new ethical issues are emerging as the health care system evolves. For example, the emergence of "Patient Care Associates" was identified as a new ethical issue. Identification and clarification of new ethical issues is needed. Staffing patterns

are also of great concern to nurses in this sample. These concerns must be documented and pursued. Nurses must take responsibility for addressing situations and practices which they identify as unacceptable. Nurses need to act cohesively to make changes at both the unit and organizational level.

According to this research, 93.2% of the respondents reported that in the past year they have used their nursing colleagues as a resource when faced with ethical issues. In fact, "nursing colleagues" were the resource most often used by nurses in this sample. It is evident from this that nurses rely on each other in difficult situations. Nurse-to-nurse communication and collaboration in clinical settings should be encouraged and promoted. Further exploration of other resources that may be useful in helping nurses resolve ethical issues and their access to these resources is imperative. Nurses should no longer have to rely solely on colleagues for support and guidance when encountering difficult ethical issues. Nurses should be encouraged to use both their code of ethics and standards of practice to guide them in addressing and resolving ethical issues.

To promote effective problem solving about ethical dilemmas, nursing communication and team collaboration should be encouraged in all practice settings. Nurses should insist on involvement in ethical rounds and membership on hospital ethics committees. Staff nurses could develop their own unit-based ethical rounds. Such forums would enable nurses to discuss ethical issues specific to their specialty area. Frequency of meetings would reflect the needs of the staff. According to the findings of this study, nurses on medical units or combined medical/surgical units more frequently encounter ethical issues than do the surgical units; and therefore, may need additional

education and support to help them resolve ethical issues. Expert nurses could teach or facilitate group discussion.

Nurses must also accept responsibility for developing their understanding of ethical problem solving. "Gut level feelings, ready made answers and personal opinions are not adequate in resolving ethical problems" (Fenton, 1987, p. 11). Nurses must recognize and meet their own learning needs. Institutions and organizations must provide opportunities for discussion and professional growth.

Nursing Education

For nurses to participate in ethical decision-making with other health care team members, they must be able to articulate their professional perspective in a logical and rational manner. To do so requires knowledge of ethical theories and principles. Basic nursing education programs attempt to address this need by offering programs that teach nurses how to make ethical decisions. Strengths of these educational experiences include exploration of students' clinical experiences and the opportunity to address ethical issues in groups. This assists students to build their confidence for future dialogue with other health care team members.

Nursing educators should use the findings of studies such as this one to critique the adequacy of current curricula related to nursing ethics and nursing practice. Educators cannot rely exclusively on anecdotal literature to develop educational programs; they must also identify current ethical issues that nurses face in the practice setting. Nursing courses on ethical theory should also provide information about the importance of resolving ethical issues, and the emotional and physical impact on nurses if they are unable to do so.

Practicing nurses also have significant educational needs related to ethics. For example, because of the type of patient population that exists on medical units, nurses may need educational programs which could help them resolve ethical issues. They should be supported by employers to attend continuing education programs. Currently, ethics courses are offered through open learning institutions which enable practitioners to continue working while upgrading their education. Nurses should also be encouraged to attend inservices and nursing forums related to nursing ethics. By attending ethical rounds within their organization, nurses would have the opportunity to explore situations as they arise in the practice setting. Nurses should also attend interdisciplinary courses on ethics in order to understand the professional perspectives of other members of the health care team.

Nurses must also be aware of the resources available to them when confronted with an ethical issue. Findings of this research indicate that nurses use a select few resources when facing ethical issues. Therefore, hospital orientations should include information on accessing and using available ethical resources.

Nursing Administration

Nurse administrators should provide nurses with the tools and support they need to resolve ethical issues with confidence. They need to understand that ethical issues have an emotional impact on nurses. Hence, nurse administrators should conduct needs assessment in their organizations to determine what kinds of support, resources, and educational programs nurses need. Nurse administrators must ensure all nurses have access to ethics committees. Policy review and development should also be conducted with staff nurses' input.

Head nurses are the most important resource persons for staff nurses. Given that 89.5% of the respondents in this study indicated that they consulted their head nurses when confronted with an ethical issue, head nurses must understand and be able to apply ethical theory. They should act as role models in interdisciplinary interaction to resolve ethical issues, demonstrating a clear and open style of communication.

Both head nurses and administrators must encourage involvement of staff nurses in interdisciplinary group meetings on ethics and clinical practice, nursing ethics rounds, and nursing forums. They must also encourage nurses to use their professional codes of ethics and nursing practice standards as guides when addressing ethical issues. Opportunities for nurses to explore and discuss the application of codes of ethics could be incorporated into orientation programs and inservice educational sessions.

Finally, nurse administrators must be alert to the distress experienced by nurses when they face unresolved ethical dilemmas. Administrators should be available to listen to and validate staff members' concerns, and provide support for nurses to work through the issues. Administrators should examine all organizational factors which might impede the power and ability of nurses to confidently address ethical issues. Only when these factors are identified can strategies be implemented to support nurses in clarifying their values, examining issues and dealing with their feelings. Nurse administrators and staff nurses must join forces to develop support systems and structures.

Recommendations for Further Research

This descriptive study is the first in British Columbia to describe the experiences of medical/surgical nurses about the ethical situations they encountered and how

disturbed they were by them. As first level research, this study has identified a number of areas that warrant further investigation. It also provides direction for refinement of the survey questions. Therefore, based on the findings of this study, the following recommendations are made:

- 1) Before being used again, the questionnaire requires further revision. Questions on the additional ethical issues nurses identified in this survey should be added. For example, additional questions related to active euthanasia, nurse/physician relationships, and Patient Care Associates should be formulated. The number of questions on DNR orders needs to be expanded and made more specific. Questions which elicited frequent comments in the margins should be examined for clarity and specificity. Survey questions should be re-ordered. Presently, questions 1, 2, and 3 relate to nursing competence. This initial focus could evoke a negative reaction, influencing the number and quality of subsequent responses. Finally, a "case history" question could be added to the questionnaire. Nurses would be asked to describe the single most disturbing ethical issue they had encountered in the past five years.
- 2) This study should be replicated with a larger sample size of medical/surgical nurses from rural and urban hospitals, and with nurses in other practice settings in order to increase the generalizability of findings and to compare experiences of nurses across the health care continuum.
- 3) Future studies need to explore some of the additional ethical issues that nurses described encountering in their practice setting (e.g. active euthanasia, DNR orders, withholding of medical intervention deemed necessary).
- 4) Qualitative research should be conducted to explore more fully the ethical issues

related to: (a) unsafe staffing patterns; (b) caring for a patient whose family is demanding futile treatment; (c) prolonging a patient's life when death is inevitable; (d) disagreeing with physicians about patient care; and (e) working with nurses who behave irresponsibly. These five areas were revealed as the most distressing for this sample of nurses. Focus group interviews would be an appropriate means of exploring and clarifying these areas.

- 5) Future research needs to explore in more depth resources nurses need to resolve ethical issues, their access to resources already available, and nurses' input into ethical decisions.
- 6) Future research needs to examine the different types of ethics education programs offered to nurses, in order to determine the effectiveness of different approaches in teaching nurses both to identify and to resolve ethical issues.
- 7) Further research which explores the emotional responses to ethical issues nurses encounter in the clinical setting is required.
- 8) Future research needs to examine and clarify terminology such as active euthanasia and patient assisted suicide.

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Appendix A
SURVEY OF ETHICAL ISSUES IN NURSING - REVISED

Thank you for agreeing to participate in this study. Your input is important and I appreciate your commitment.

Directions:

Ethical issues are disputes involving different points of view about what constitutes ideal moral conduct. Listed on the following pages are some common situations involving ethical issues nurses may encounter in their practice.

For each ethical issue please make two responses.

- The first response refers to how frequently this specific situation has happened in your practice during the past year.
- The second response is your evaluation of how disturbed (i.e. uneasy; upset, mentally or emotionally) you get or would get if you did encounter this issue.

Please circle the number that best represents your response in each category. Feel free to make any comments next to any item.

How FREQUENTLY has this happened in the last year?	How DISTURBED did you get when you encountered this situation?
0 Never	0 Not at All
1 Rarely	1 A Little
2 Occasionally	2 Somewhat
3 Frequently	3 Quite a Bit
4 Very Frequently	4 A Great Deal

Section I

Issues

- | | | |
|---|-----------|-----------|
| 1. You know that a nursing colleague has failed to report a medication error. | 0 1 2 3 4 | 0 1 2 3 4 |
| 2. You are faced with making a decision about reporting an incompetent colleague (e.g. clinically outdated, poor technical skills, etc.). | 0 1 2 3 4 | 0 1 2 3 4 |

Survey of Ethical Issues in Nursing - Revised (Cont'd.)

	How FREQUENTLY has this happened in the last year?	How DISTURBED did you get when you encountered this situation?
	0 Never 1 Rarely 2 Occasionally 3 Frequently 4 Very Frequently	0 Not at All 1 A Little 2 Somewhat 3 Quite a Bit 4 A Great Deal
3. You know that a nursing colleague's work performance is affected by substance abuse (alcohol and/or drugs).	0 1 2 3 4	0 1 2 3 4
4. Your patient has unclarified code orders and you are asked to participate in a slow code or partial code.	0 1 2 3 4	0 1 2 3 4
5. You are aware that the family of a competent elderly patient are seeking power of attorney without his/her knowledge.	0 1 2 3 4	0 1 2 3 4
6. You know that a nursing colleague has failed to report an error of omission (e.g. missed drug/treatment).	0 1 2 3 4	0 1 2 3 4
7. You are aware of illegal activity of a nursing colleague(s) (e.g. altering patient's records, stealing from hospital supplies, etc.).	0 1 2 3 4	0 1 2 3 4
8. You know information about prognosis is being withheld from the patient and/or family.	0 1 2 3 4	0 1 2 3 4
9. You are aware that confidentiality of a patient's records is violated.	0 1 2 3 4	0 1 2 3 4

Survey of Ethical Issues in Nursing - Revised (Cont'd.)

	How FREQUENTLY has this happened in the last year?	How DISTURBED did you get when you encountered this situation?
	0 Never 1 Rarely 2 Occasionally 3 Frequently 4 Very Frequently	0 Not at All 1 A Little 2 Somewhat 3 Quite a Bit 4 A Great Deal
10. You are faced with unsafe staffing patterns (e.g. high patient-nurse ratios, frequent double shifts, excessive overtime, etc.).	0 1 2 3 4	0 1 2 3 4
11. You advocate on a patient's behalf and face a disagreement with a physician over patient care.	0 1 2 3 4	0 1 2 3 4
12. You know one of your patients has consented to a medical procedure which he/she does not understand.	0 1 2 3 4	0 1 2 3 4
13. You know that the patient and/or family has not received complete information about a scheduled procedure/treatment.	0 1 2 3 4	0 1 2 3 4
14. You have to work with inadequate and/or out-dated equipment.	0 1 2 3 4	0 1 2 3 4
15. You are caring for a patient whose family is demanding futile treatment.	0 1 2 3 4	0 1 2 3 4
16. You work with a nurse who regularly behaves irresponsibly (e.g. inappropriate sick calls, extended break periods, etc.).	0 1 2 3 4	0 1 2 3 4

Survey of Ethical Issues in Nursing - Revised (Cont'd.)

	How FREQUENTLY has this happened in the last year?	How DISTURBED did you get when you encountered this situation?
	0 Never 1 Rarely 2 Occasionally 3 Frequently 4 Very Frequently	0 Not at All 1 A Little 2 Somewhat 3 Quite a Bit 4 A Great Deal
17. You are aware of unreported incidents of patient abuse (psychological or physical) by nursing staff.	0 1 2 3 4	0 1 2 3 4
18. You have a patient whose life is being prolonged with heroic measures although death is inevitable.	0 1 2 3 4	0 1 2 3 4
19. You are caring for a patient who is receiving treatment despite his/her objection.	0 1 2 3 4	0 1 2 3 4
20. You know that family members of an elderly patient are trying to convince him/her to refuse necessary treatment.	0 1 2 3 4	0 1 2 3 4
21. You are asked to practice nursing in a way that violates your personal values (e.g. caring for a patient who is having an abortion, assisting with ECT, etc.).	0 1 2 3 4	0 1 2 3 4
22. You know that confidential patient matters are being discussed in public.	0 1 2 3 4	0 1 2 3 4
23. You are working with a physician who demonstrates inadequate knowledge and skills to provide safe medical care.	0 1 2 3 4	0 1 2 3 4

Survey of Ethical Issues in Nursing - Revised (Cont'd.)

	How FREQUENTLY has this happened in the last year?	How DISTURBED did you get when you encountered this situation?
	0 Never 1 Rarely 2 Occasionally 3 Frequently 4 Very Frequently	0 Not at All 1 A Little 2 Somewhat 3 Quite a Bit 4 A Great Deal
24. You are asked to work in a clinical setting for which you do not have the specialized skills and knowledge.	0 1 2 3 4	0 1 2 3 4
25. You are aware that a patient is being restrained unnecessarily.	0 1 2 3 4	0 1 2 3 4
26. As the patient's nurse, you have not been consulted about your personal ethical conflicts related to the care you are required to give.	0 1 2 3 4	0 1 2 3 4
27. What ethical issues have you faced in the past year that were not described in the questions above?		

Section II**Directions**

Circle yes or no for each of the following four statements.

- | | | |
|---|-----|----|
| 28. Do you possess a copy of the CNA Code of Ethics? | Yes | No |
| 29. Have you referred to the Code of Ethics in the past year? | Yes | No |
| 30. Are you familiar with the R.N.A.B.C. Standards for Nursing Practice (1992)? | Yes | No |
| 31. Have you used the R.N.A.B.C. Standards for Practice in the past year? | Yes | No |

Section III

32. Please check the resource(s) you have used in trying to resolve ethical issues in the past year. (✓) if used

- | | |
|--|-------|
| A. Hospital Chaplain | ----- |
| B. Head Nurse/Nurse Manager | ----- |
| C. Nursing colleagues | ----- |
| D. Nursing Instructor | ----- |
| E. Clinical Nurse Specialist/Clinical Resource Nurse | ----- |
| F. Director of Nursing | ----- |
| G. Nursing Consultant | ----- |
| H. Physician | ----- |
| I. Social Worker | ----- |
| J. Nursing ethics rounds | ----- |
| K. Educational sessions on ethical principles | ----- |
| L. Consultation with an ethicist | ----- |
| M. Institutional ethics committee | ----- |
| N. Literature | ----- |
| O. Family Members | ----- |
| P. Other _____ | ----- |
| (specify) | |

Section IV**BACKGROUND INFORMATION**

I would like to know a few facts about yourself. This information is for statistical analysis only. Please check whichever description applies to you and fill in the requested information.

1. Nursing Education

Please check the highest level of education you have completed.

- ☐ Two year diploma program
☐ Three year diploma program
☐ Post-basic baccalaureate program
☐ Four year university program
☐ Master's program or higher
☐ Other (please specify): _____

2. Area in Which You Currently Work

- ☐ Medical Unit ☐ Combined Medical/Surgical Unit
☐ Surgical Unit

3. Number of years you have practiced as a nurse. _____ years
 4. Number of years you have worked in medical and/or surgical nursing. _____ years
 5. What was your age on your last birthday? _____ years

6. Gender

- ☐ Female ☐ Male

7. How many beds does your hospital have? _____ beds
 8. In what city/town is your hospital located? _____

Thank you for completing the questionnaire. Please return in the envelope provided.

Appendix B

Dear Colleague:

My name is Debbie Hollands. I am a graduate student at the University of British Columbia School of Nursing, and I am conducting a research study entitled "Survey of Ethical Issues in Nursing" for my Master's thesis. My faculty advisor is Dr. Sonia Acorn.

Medical/Surgical nurses face many complex and difficult ethical dilemmas in their practice. The purpose of my research is to identify which ethical issues nurses face most frequently and describe how disturbed they are by these situations.

Your name has been randomly selected to receive this package by the RNABC computer bank. This service is paid for by the investigator. I am not aware of the identities of the names selected in order to ensure complete anonymity. Your participation in this study is voluntary. A completed questionnaire will be viewed as an indication that you have consented to participate.

Please find enclosed in the package a questionnaire consisting of three sections. Section One asks you about the frequency with which you have encountered specific ethical issues in the past year, and how disturbed you were by these issues. Section Two asks you four questions relating to your understanding of professional standards. Section Three asks you to check the resource(s) you have used in trying to resolve ethical issues in the past year. Also enclosed is a biographical information form; results will be correlated with your responses to the questions about ethical issues.

Should you agree to complete this questionnaire as part of my study, your contribution will be most appreciated. You have the right to decide not to participate, or to refuse to answer any questions. All information is confidential and you are not required to identify yourself in any way. A copy of the research results, when completed, can be made available upon request.

We need to know more about the ethical dilemmas nurses face. By understanding the perspective of bedside nurses, our profession can develop better strategies to help caregivers, patients and families work through difficult choices and decisions. Please take 15 minutes to complete these questionnaires.

If you have any questions about this study, please contact me at XXX-XXXX or Dr. Sonia Acorn at XXX-XXXX. Thank you in advance for your cooperation.

Sincerely,

D. Hollands, R.N., B.S.N.
Encl.