MULTIPLE LOYALTY CONFLICTS IN NURSING

By

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Abstract

MULTIPLE LOYALTY CONFLICTS IN NURSING

The International Council of Nurses [ICN] Code for Nurses clearly states that the registered nurse's first obligation is to the patient (ICN, 1973). But, in the clinical setting, multiple loyalties or obligations to the patient, family, physician, employing agency, professional standards, and personal ethical beliefs may conflict. Given the diversity of obligation in nursing practice and the ever expanding array of life sustaining technologies and techniques, a problem arises for nurses when they attempt to employ clinical guidelines offered by the ICN Code. Therefore, in order to ascertain how nurses uphold patient autonomy when responding to conflicts in the empirical setting and to delineate the patterns of reasoning which contribute to the actual response as well as to the preferred response, a qualitative grounded theory methodology was selected. This exploratory approach provided evidence that when conflict occurs, perceptions of relevancy on both a cognitive and affective level, influence the nurses' response. Often nurses with apparently equal cognitive capabilities on a moral developmental level perceived conflict of loyalty situations in vastly different ways and thereby responded with a range of behavior that went from exemplary care, which supported patient autonomy, to unsafe care, which completely denied patients their autonomy. An inductively derived substantive theory outlines this variance in care. The manner in which patient
autonomy is upheld in multiple loyalty conflicts can be expressed on a three dimensional categorical basis with perceptions of imposed, bounded and volitional relevance conjoined with three levels of cognitive moral development, including both descriptive and normative explanations of conflict resolution. Principles and their supporting rules for nursing action derived from each category emphasize the little researched but complex relationship between moral cognitions, perceptions and affective valuing.
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Chapter One: Introduction

Background to the Study

The International Council of Nurses [ICN] Code for Nurses clearly states that the registered nurse's first obligation is to the patient (ICN, 1973). But, in the clinical setting, multiple loyalties or obligations to the patient, family, physician, employing agency may conflict with professional standards and personal ethical beliefs. Given the diversity of obligation in nursing practice and the ever expanding array of life sustaining technologies and techniques, a problem arises for nurses when they attempt to employ the clinical guidelines offered by the ICN Code. O'Rourke (1983) believes that basic consciousness raising endeavors are needed if the ICN Code is to be truly implemented in nursing practice. Davis (1980) concurs and notes that nurses need skills in identifying the ethical dimensions of their practice, plus the confidence to act on well reasoned decisions which are based on ethical principles.

Schlotfeldt (1981) maintains that in order to assess and enhance the general health status, health assets, and health potentials of human beings, and thereby support the dignity and rights of those we care for, nurses require a sharper conceptual focus in seven areas—one of these being the accurate selection of scientific, humanistic, and ethical content. Systematic inquiry into this area, she argues, will promote increased feelings of accountability and
autonomy within the nursing profession. Gortner (1974) builds on this idea; she stresses the fact that intellectual freedom and individual self direction "are at the very heart of accountable practice" (p. 767) and that these attributes require sound decision making skills. To this end, nursing has evolved an ethical code that places heavy emphasis on the accountability of the nurse for quality of care and on her duty to act as a patient advocate.

The ICN Code, itself, is founded on basic normative standards and consists of a set of rules from which the nursing profession establishes its duties and obligations (Beauchamp & Childress, 1979). However, it is the ethical principles inherent in these standards which must be referred to in the problematic cases where loyalties conflict, for example, when invasive therapies interfere with upholding the dignity of the individual. Specifically, the concept of autonomy—liberty of action based on informed choice (Storch, 1982), is addressed in this case. Patient autonomy is a component of the ethical principle of autonomy and its meaning is grounded in the ICN Code of ethics. This principle follows from the ICN Code's directive to promote patient rights and to uphold patient dignity by respecting the beliefs, values and customs of each individual (ICN, 1973). It endorses the ethical aspect of professional nursing practice by referring to the responsibility and trust which has been invested in the nursing profession by society. When it is adhered to it leads to decisions that meet the requirement of scientific
accountability, promotes a sense of autonomy and contributes to the humanitarian and caring dimension of nursing.

Thus, principles provide nurses with a way of organizing the raw data of experience (Davis, 1982), and the principle of autonomy, as it is addressed in the concept of patient autonomy, provides a focus for this study as ethical issues in nursing practice are discussed. But, quality decisions require more than conceptual focus: critical thinking based on a certain pattern of reasoning is essential.

To this point, Kohlberg (1981) developed a theory of cognitive moral development. One assumption of this theory is that the quality of a decision outcome can be determined by identifying the pattern of reasoning with which the individual justifies the decision (Kohlberg, 1981). Kohlberg links specific reasoning patterns to levels and stages of moral development. He cites three levels which incorporate six stages through which people can progress. Each stage provides the individual with a more comprehensive perspective on the effect of society on individual rights.

Thus, to actually understand the modes of thinking that contribute to resolution of conflict of loyalty decisions, it is necessary to explore the patterns of reasoning that underlie the outcome; plus, in order to assess the effect of the contextual nature of the situation and to see if patterns of reasoning are affected, it is necessary to expand the exploration to include a rationale for a preferred outcome.
Problem Statement
This study focuses on multiple loyalty conflicts which involve problems pertaining to patient autonomy and explores the underlying patterns of reasoning which serve to substantiate rationales for both the actual and the preferred decision outcome.

Definition of Terms
Multiple Loyalty Conflict
Any incongruence of demand or desire between the patient, family, physician, employing agency, personal ethical beliefs and professional ethical standards of the individual registered nurse.

Patient Autonomy
The patient's right (or the incompetent patient's surrogate) to have beliefs and values respected when making informed choices for action.

Patterns of Reasoning
The level and stage of cognitive moral development as defined by Kohlberg's theory of cognitive moral development.

Decision Outcome
The conflict resolution including both the actual and the preferred outcome.

Purpose of the Study
The purpose of this study is to identify the patterns of reasoning which registered nurses use to resolve multiple loyalty conflicts involving patient autonomy, and to compare this reasoning
with the pattern of reasoning that depict a preferred outcome. The purpose includes the following objectives:

1. Identification of multiple loyalty conflicts involving patient autonomy.

2. Outlining of pertinent data related to the decision making process.

3. Discovery of concepts, categories, and themes that are grounded in data.


5. Comparative analysis of the rationale for the decision outcome and the pattern of reasoning which supports a preferred outcome.


**Methodological Perspective**

**Research Design**

A qualitative, grounded theory methodology suitably fits the exploration of decision making processes when the purpose is to generate concepts which explain action. This design choice is based on the fact that little is known about how the ethical dimension of the reasoning process relates to action and, thereby, to modes of resolving multiple loyalty conflicts in nursing. This design calls for a ten step process: (a) setting out a general problem area; (2) gathering relevant empirical data; (c) comparing the data;
(d) formulating concepts; (e) organizing concepts; (f) developing core concepts into an explanatory framework; (g) critically comparing the empirically derived concepts in the framework with those in the literature; (h) reducing the number of concepts; (i) refining the conceptual definitions; and, finally, (j) developing an abstract theoretical perspective.

Three studies which deal with the general topic area are particularly relevant to this study, two are by Ketefian (1981a, 1981b) and one is by Crisham (1980).

Ketefian (1981a) focused on the relationship between critical thinking, educational preparation, and level of moral judgment in relation to a selected group of 79 registered nurses. She found that critical thinking and educational preparation together predict greater variance in moral judgment than either variable alone. She contends that it is necessary to develop valid and reliable tools for measuring the resulting moral behavior among nurses and to investigate the exact nature of the relationship between thinking, judgment, and behavior.

Later that same year, Ketefian, utilizing the same sample, completed another study (1981b). Here, she attempted to ascertain the relation between moral reasoning as it is related to ideal versus realistic behavior. Yet, while noting that this area of study requires further methodological consideration, Ketefian does discover what she terms "distressing" knowledge about the relationship between
what nurses value and how they believe they would respond in reality; she believes that the bureaucracy may be at fault by forcing the nurse to accept the values of the organization.

Of a similar nature is a study by Crisham (1980). She compared nursing responses to both general moral dilemmas as well as to specific nursing related moral dilemmas. Plus, she analyzed responses in relation to such variables as education, experience, and familiarity with the specific dilemma. In doing this, she found that the level of education and familiarity with dilemmas tended to lead toward more principled thinking, but that the moral judgment scores of staff nurses were lower than those of pre nursing students. This discrepancy, Crisham postulates, could be due to hospital milieu effects on nursing practice. Hence, she concludes with the statement that in order to advance knowledge of moral judgment, it is necessary to clarify "situational pressures", conflicting claims and contexts of professional dilemmas, and to further investigate the interaction of these milieu effects (p. 110).

In all, the three studies establish that there is concern about nurses and their ability to make ethical decisions. While variables such as critical thinking ability and educational level were cited as having a significant but not large influence on the decision making ability of a nurse, there was really no causal or predictive information forthcoming. However, as mentioned, Crisham's study did note a possibly important intervening variable—the hospital milieu or, perhaps we could say, the bureaucratic milieu.
Ketefian and Crisham have identified an area most worthy of study. Their findings raise more questions and in general direct research back to the reassessment of milieu effects. In order to truly assess the contextual nature of the problem, a qualitative exploratory approach is needed; this approach explores the registered nurse's view of the substantive situation. Concepts and themes which are grounded in the nurse's subjective world view may help identify as yet unknown variables which will add to what is already known about patterns of reasoning in conflict situations of an ethical nature.

**Thesis Organization**

Chapter One is designed to provide a basic overview of the study. Chapters Two and Three present a more detailed conceptual framework and a complete discussion of the research design. Analysis of data follows in Chapter Four. Part One of this chapter lists the range of multiple loyalty conflict situations that were brought forward by the respondents. In addition, it identifies dimensions of the major substantive concepts and provides a refinement of concepts based on collateral literature. The grounded conceptual schema is then integrated into Kohlberg's theoretical framework. Keeping the integrated substantive and theoretical perspective in mind, Part Two continues the analysis by identifying thematic issues for each category of the framework and by utilizing concrete examples to explain the varying patterns of reasoning. Again, literature is
used as a critical, comparative resource. Chapter Five, providing a more abstract rendition of the data, presents a grounded theoretical perspective which attempts to account for discrepancies in patterns of reasoning. A brief summary of the study, a list of conclusions and a discussion of implications and recommendations pertinent to the four key areas of nursing education, practice, administration, and research follows in Chapter Six.
Chapter Two: Conceptual Framework

Introduction

The purpose of the conceptual framework is to interrelate the facts, concepts, principles, and theories which underpin the research problem and, consequently, support the purpose of the study. Many of the ideas utilized in this study come from other disciplines because ethical concerns in health care reach into such areas as philosophy, psychology, and education. In particular, reference will be made to Beauchamp and Childress (1979), Cassel (1983), and Veatch (1976), all modern philosophers. Background philosophical insight is provided by Kant and Mill, two 18th and 19th century philosophers who were instrumental in developing theoretical perspectives pertaining to contemporary ethical thought and action. In addition, psychology and education are represented by Kohlberg (1981). His contribution to the understanding of moral development and ethical thought took another step forward as research findings which pointed to patterns of reasoning became discernible.

The conceptual framework requires a synthesis of thought from various areas; however, each conceptual and theoretical focus is utilized to stress the central importance of the concept patient autonomy and its critical relationship to present day nursing practice. The framework, in following an inductive expansion, firstly, presents an outline of the obligations in nursing; secondly, it grounds these obligations in a higher order ethical principle;
then, discusses how nursing obligation requires ethical decision making; and, finally, places ethical decision making into the context of cognitive moral development theory. A brief summary at the end of the chapter ties the conceptual framework together schematically and prepares one for the manner in which the data is analyzed.

**Obligations in Nursing**

Inherent in nursing is respect for life, dignity, and the rights of the individual. These tenets are upheld in the Nurses (Registered) Act (1979), the CNA Standards for Nursing Practice (1980), and are outlined in the ICN Code for Nurses (1973). These three documents provide an interface for justice, standards, and duties, and delineate the role of the registered nurse. While this study focuses on the ethical implications of nursing practice as formulated by the ICN Code for Nurses, ethical guidelines are founded within a legislated and professionally defined context.

For example, the nursing practice act, formally a product of the provincial legislative body, functions to regulate the scope and intent of practice for registered nurses in British Columbia. The overall aims of the Act is to protect the interests of the citizens of this province. The constitution and bylaws, sublegislation for the purposes of carrying out the Act, speak to societal values. Nurses are to "further the standards of nursing practice" and "to engage in activities that are conducive to the health and welfare
of the public and the welfare of nursing and allied professions" (Nurses [Registered] Act, 1979, p. 1). This statement not only justifies nursing's raison d'être and is vital to our philosophical basis for caring, it also stipulates that there are parameters on which to base criminal and civil liability. Nurses, in fact, have legally been given a mandate—a right to practice.

These general statements are supported in a more specific fashion in the CNA Standards for Nursing Practice (1980). This document outlines four standards which help clarify areas of nursing accountability while taking into account the independent, interdependent, and dependent functions of nurses (see Appendix A). It clearly stipulates that nurses "direct their energies toward the promotion, maintenance and restoration of health, the prevention of illness, the alleviation of suffering and the ensuring of a peaceful death when life can no longer be sustained" (CNA, 1980, p. v).

The ICN Code of ethics functions as a further guide for accountable action (see Appendix B). It provides rules for action which are designed to protect the patient and represents an articulated statement of role morality as seen by the members of the profession (Beauchamp & Childress, 1979). However, while nursing has evolved an ethical code that places emphasis on the accountability of the nurse for quality of patient care and on the duty to act as a patient advocate, conflicts are occurring. Nurses are caught by competing demands which require opposing courses of
action and the rules do not provide adequate guidance. For example, an adolescent girl with a terminal illness asks the nurse if she is dying, but her father does not want her to know, yet the nurse believes she is mature enough to cope with the knowledge. Or, immediately after the nurse witnesses a patient sign his surgical consent form, he turns and with fear in his voice, states he may have made the wrong decision and may not know enough about the surgery and, furthermore, the nurse knows that the patient is a poor candidate for surgery and that he was not told of the high risk of stroke that accompanies such an operative procedure. In such cases, it is clear that the nurse's obligations are in conflict.

With such conflicting loyalties, how can obligations be met? Davis (1980) states that an understanding of the ethical principles which underlie the ICN Code will help the nurse organize the data, conceptualize the experience, and, thereby, be able to articulate a more thoughtful stance.

**Ethical Principles in Nursing**

Thus, there is a need to formulate a principled context to nursing practice by becoming somewhat more general and looking at the principled base of the ICN Code. While several ethical principles underlie the ICN Code, one is of particular importance for this study: the principle of autonomy. This principle is rooted in ideas relating to freedom of choice backed by personal responsibility for action.
Kant in 1785 wrote about the notion of self-legislation in accordance with rationally chosen moral principles. His contention was that when these principles were selected with thought given to their universality and generalizability and, further, when considered ends in themselves, they would lead to right and humanitarian action (Aune, 1979). It is evident that Kant strongly favored a principle of autonomy and saw a need to enjoin action with autonomy. In theory he actually proposed that the principle of autonomy must be a necessary condition for moral judgment (Paton, 1964). Yet, while Kant favored the idea, Mill, in 1863, adopted a more empirical bent. Mill (1910/1977) believed that different persons required different conditions for their healthy development and advocated the need for individual diversity, originality, and self determination, insofar as they do not interfere with the rights of others and, as a consequence, promote an overall good for the greatest number in society. Once again, then, liberty of action comes to the forefront: the freedom to choose rationally remains a central ingredient for both philosophers.

In the ICN Code, the principle of autonomy is evident in the statement supporting the individuals' right to act on their own values according to their own beliefs (ICN, 1973). These directions give the nurse the right to promote the individual's ability to "set goals and make decisions" (ICN, 1973). Secondly, it points to the individual's right to information. For as Cassell (1983)
notes, autonomy is impossible without the information on which to base action. To have a free choice, one must know what choices are available. Finally, the nurse must consider the patient's right to the truth, and according to Veatch (1976), it is the individual's right and obligation to have the truth. He notes that "rarely is withholding information potentially useful or meaningful to the patient to be condoned" (p. 248). Although there are rare times, he admits, when this contingency must be taken into account; nevertheless, the justification for nondisclosure rests with the person who withholds. This point of view is soundly upheld by the President's Commission (1983) in their latest document on ethical, medical, and legal issues in health care. The Commission states that rarely "is incapacity absolute," hence, individual decision making capacity should be examined in each situation; furthermore, the criteria for assessment should be based on lay person criteria (i.e., one asks whether a lay person would judge the individual to have reasonable ability and understanding) (p. 123). Evidently, after thoroughly considering ethics and health care, the Commission believes that the principle of autonomy holds prime value in our society today.

A principle that has such force behind it cannot and must not be set aside. Yet, with the ever present and expanding array of technologies and techniques available in health care, very complex human situations arise. How can nurses follow this principle so
that legal and ethical directives are upheld? Arsokar (1982) believes that nurses are challenged as never before and that they must critically examine the moral dimensions of decision making. She stresses that the process of ethical inquiry must include principled thinking, reflective decision making, and strategies for action, all performed within a spirit of compassion and with the knowledge that nurses are members of a profession fulfilling a social contract.

**Ethical Decision Making**

One goal of ethical inquiry is the promotion of accountable behavior where accountable means that one is responsible and answerable for one's actions (Fenner, 1980). In order to make accountable decisions, Fenner contends that nurses must have the ability to control their practice within appropriate set boundaries. Herein lies the problem—the need for a more explicit refinement of the legal and ethical boundaries of nursing practice.

Arsokar (1982), when she brings up the contentious issue of mind sets, seems to capture the essence of at least part of the problem. She identifies three views of nursing mind sets and notes how each view has implications for ethical practice and conflict resolution. Either mind sets are directed firstly by the medical model, secondly by the institution's commodity view, or thirdly by the patient advocacy perspective. The defining boundaries for nursing practice are often dependent on how individual nurses view each mind set.
When nurses view themselves through the medical model, they often see themselves as having a solely dependent role and functioning as "a safe sounding board" for others (Arsokar, 1982, pp. 24-25). At this point, they may be totally unaware that they are involved in a situation requiring nursing consideration of ethical elements. Similarly, when nurses view themselves as part of an institution which promotes health care as a commodity with efficiency and productivity to the foreground, they may feel primarily responsible to the administrative hierarchy: right and wrong may be dictated by institutional goals and policies that have not had active nursing input. Finally, if the nurse sees patients' needs as primary without critiquing the relevance of the need, societal resources can be depleted and professional integrity lost (Arsokar, 1982). Arsokar goes on to say that each mind set leads to a certain view of correct action which may not, in fact, meet criteria necessary for professional and ethical nursing practice.

When professional ethics are not upheld, the nurse is vulnerable to reprimand, censure, suspension, or even loss of licensure, if the Association takes action (Arsokar & Davis, 1978). What is more, in some cases, basic safe practice is in jeopardy and a nurse can be found either directly or vicariously liable by the courts. True professional practice implies a higher order of obligation—an order which encompasses principled decision making founded on professional standards and ethical values (O'Rourke,
1983). It is only when this is possible that the scope of nursing practice encompasses the three dimensional focus with independent, interdependent, and dependent elements of practice given appropriate consideration.

Actualizing the three dimensional nature of nursing practice requires the ability to think critically about complex ethical and human problems. In considering how this is to be done, a nursing theorist, Curtin (1979) developed a model for decision making which incorporates seven categories for data: background information, ethical components, ethical agents, options, application of principles, resolutions, and actions. These categories provide for the elucidation of situation and ethical factors as well as providing for comparisons with societal sanctions and legal constraints as necessary.

With this model, the decision making process can then be ensured to encompass a full exposition of the problem, consideration of several options, and a thoughtful resolution prior to action—decision making becomes a very systematic process. Ethical principles, when used in conjunction with the model, provide specific guidance and help the nurse differentiate between more and less appropriate solutions. Indeed, in conflict situations, it is even more necessary to use the model efficiently in order to cope with both intrapersonal, interpersonal, and interprofessional differences as well as to resolve the issue. Furthermore, while the model should be used efficiently, effective use, in the sense of the quality of reflective thought
utilized, is also necessary if ethical guidelines are to be upheld. Because, as Janis (1982) notes, when individuals are confronted with choices between complex multivalued alternatives, many will simply avoid the "unpleasant cognitive and emotional work" involved in the decision process (p. 5). Effective model use, then, requires careful thought and an assessment of such thought can be made by a study of cognitive moral development theory.

Theory of Cognitive Moral Development

In constructing a comprehensive explanation of cognitive moral development, Kohlberg looked to the patterns of reasoning with which individuals justify a decision (Hersch, Miller, & Fielding, 1980). He discusses specific patterns of reasoning through which people can progress and organizes the patterns into three levels each having two stages (Hersch, Paolitto, & Reimer, 1979).

Levels and stages can be understood as follows. Levels of moral judgment are general ways of defining what is right and are supported by a certain viewpoint or social perspective (Duska & Whelan, 1975). Stages, more concrete entities, depict the quality of organized possibilities and underlying thought patterns that characterize the reasoning process at a given time (Hersch, Paolitto, & Reimer, 1979). Kohlberg claims that stages form an invariant sequence or order in development with thought patterns in the higher stages showing increasing cognitive differentiation and integration (Duska & Whelan, 1975).

Consider now how Kohlberg has fit the two concepts of level
and stage together. A person at the first level, the preconventional level, approaches a moral issue from an individualistic point of view with concern for concrete consequences. Stage one and two fall within this level. Stage one, heteronomous morality, focuses on right as being blind obedience to rules and authority; one does what is right to avoid punishment. In stage two, with individualism, instrumental purpose and exchange in the foreground, right is defined as following rules when they are to one's concrete immediate interest. Right is relative. Deals are accepted. One does what is right to meet one's own needs while recognizing others have needs. People at level two are at the conventional level. They approach a moral problem from a member-of-society perspective and the concern is to be a good role-occupant while protecting society's and one's own interests. Stage three and four are encompassed at this level. Stage three people rely on mutual interpersonal expectations, relationships, and interpersonal conformity. Right is trying to live up to what is expected. In trying to be a good person in one's own eyes and those of others, people desire to maintain rules and authority that support stereotypical good behavior. This point of view follows the Golden Rule and trust, loyalty, respect, and gratitude are important. Stage four is the social system and conscience stage, here people seek to fulfil duties to which they have agreed and to uphold laws unless they conflict with other social duties. The aim is to keep the institution going so to avoid breakdown in the social system. Here, individual actions are
considered in terms of their place in the system; right is ensuring that one meets one's defined obligations as roles and rules dictate. A person at the last level, the postconventional level, or principled level, approaches a moral conflict from a prior-to-society perspective. This perspective encompasses seeing beyond the laws and given norms of self and society in order to seek principled stances. Stage five and six are represented here. Stage five bases action on the idea of social contract or utility and individual rights. People at this stage recognize that others may have different values and that some values may be relative to a group. However, nonrelative values such as the right to life and liberty are upheld consistently. In essence, right is adhering to the social contract because its aim is to promote the welfare of all. Stage six, the final stage, refers to rational commitment to universal ethical principles. At this stage, people follow self chosen ethical principles. These principles pertain to justice, equality of human rights, and respect for the dignity of human beings as individuals; right is seeing people are ends in themselves and always treating them as such (Hersch et al., 1979).

It is this inquiry into reasoning about ethical and moral issues that has become the hallmark of Kohlberg's work. He notes that significant differences in the maturity of the reasoning process becomes apparent when individuals substantiate their judgment or actions with reasons (Duska & Whelan, 1975). Thus,
Kohlberg places major emphasis on the level and stage of reasoning utilized when an action or endpoint is being justified.

Bearing the above points in mind, it is of pertinence to this study to note that Kohlberg's theory has been criticized. Three authors in particular warrant examination. First, Hersch et al. (1979) and Sullivan (1977) believe that Kohlberg has paid too little attention to the emotional side of reasoning and, consequently, to the relationship between knowing what is principled, right, or just, and acting on their knowledge. They both refer to individually perceived risks embedded in situational factors and to the various rational motivations involved in these cases.

In addition, Gilligan (1983), in agreement, states that thought and action are inherently dialectical processes, with one intimately affecting the other: thought and action fuse within the contextual nature of the situation so that judgments often depend on the way the problem is framed. In fact, Gilligan (1982) is interested in the relational aspects of decisions made by women. She notes how different forms of self definition in women—forms based on connectedness and interrelationships—can shift individual focus from what is right to what is the most caring. Thus, women, she says, are pulled between compassion and autonomy.

Interestingly, Kohlberg (1981) has responded to this critique by concluding that yes, it is necessary to inquire into the process
of moral judgment and decision making that underlies action within a set context. He says that in order to do this, actual experiences must be delved into such that the individual's practical pattern of reasoning can be elicited. Here, moral choice and action occur within the context of a social group. Moreover, Kohlberg now notes that the social group can have a profound influence on the emotions and motives of the decision maker. Action at this time may be more a function of what is enforced by the group than of the individual's stage of moral development.

This latter form of decision and action, one based on real world performance, is called descriptive ethics: one cites what actually occurs. Reference to normative ethics is made when what should have happened, or what one would have preferred, is elicited. Obviously, what is needed in nursing is a closer view of both descriptive and normative ethics in multiple loyalty conflict situations. This view encompasses the dichotomy between facts and values; between real world pragmatics and ideal world prescriptions.

Summary

In review, it will be helpful if the key factors which provide structure for the conceptual framework are integrated schematically. This can be done by diagraming Curtin's decision model and adding both descriptive and normative elements that fit with the theory of cognitive moral development.
Figure 1 provides a review to the researcher's analytic use of Curtin's (1978) model. Each category is now specific to this study and functions as a tool for data gathering.

**Figure 1.** Ethical decision making model.

Features that are essential to the study problem are added to a more refined view of the final two categories of the model in Figure 2. Here, it can be seen how and where Kohlberg's theory is applied and, in fact, how it has been extended to include a comparison of rationales for normative and descriptive resolution processes and their correlative outcomes.

<table>
<thead>
<tr>
<th>Resolution: Descriptive Perspective</th>
<th>Action: Performed</th>
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<tbody>
<tr>
<td>Preconventional</td>
<td></td>
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<tr>
<td>Stage I</td>
<td>Conventional</td>
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<tr>
<td>Stage II</td>
<td>Stage III</td>
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<td>Stage II</td>
<td>Stage IV</td>
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<td>Stage II</td>
<td>Stage V</td>
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<tr>
<td>Stage II</td>
<td>Stage VI</td>
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<tr>
<td>Resolution: Normative Perspective</td>
<td>Actual Outcome</td>
</tr>
<tr>
<td>Level and Stage</td>
<td>Action: Preferred</td>
</tr>
</tbody>
</table>

Figure 2. Structural components of cognitive comparisons.

The overall concern of the study is with reasoning and the patterns that come forth when a registered nurse is faced with multiple loyalty conflicts. The decision model is used as a data collection tool and the concept of patient autonomy is used because of its central meaning to nursing and because of its direct relevance to moral and ethical issues.
Chapter Three: Research Design

Introduction

A qualitative grounded theory approach is most appropriate when the researcher intends to explore an area in which little prior knowledge has been found (Diers, 1979). While to date no studies have been identified that pertain to the multiple loyalty problem itself, studies such as those by Ketefian (1981a, 1981b) and Crisham (1980) refer to the ethical area of nursing practice. These studies support the need for further research into the nurse's subjective experiences when ethical conflicts arise.

Once individual subjective experiences of conflict within the social situation are obtained, it is in keeping with grounded theory methodology to identify variables which explain action. These variables can then be clustered into substantive concepts: concepts embedded in the experiences themselves. In other words, abstractions are sought (Diers, 1979; Glaser, 1978). This means that important aspects of the decision process in multiple loyalty conflicts are analyzed so that the concepts and subsequent themes are woven out of pragmatic examples of real world situations. These concepts, according to Glaser, not only fit the data, they must be interrelated in such a manner that the main contextual problems emerge. Thus, the conceptual level of the conflict situation is raised in a truly inductive fashion because the core concepts are grounded in data. The core concepts and evolving themes are then
looked at in relation to Kohlberg's cognitive moral development theory and, correlatively, compared to other appropriate literature sources. The aim is to develop a theoretical construct which describes the contextual nature of reasoning in multiple loyalty conflicts.

In order to activate this design, particular methodological steps were taken. An explication of each step will further elucidate the research process.

**Methodology**

**Selection of Participants**

Eleven registered nurses were selected from a large urban area in British Columbia. Criteria for selection were based on (a) the respondent's ability to speak English fluently, to provide for clarity in communication; (b) the timing of graduation being prior to the summer of 1983, to guard against data due to the initial reality shock of the new graduate; and (c) a working schedule of at least half-time, to ensure adequate patient contact time.

The respondents were selected via a method of intraprofessional referral: given the sensitive nature of the data required, it was felt that intraprofessional referrals would ensure protection of privacy and alleviate any anxiety the registered nurse may feel if his or her comments were in any way associated with a particular institution or agency. In order to do this, information was circulated informally through colleagues who provided the investigator with the name and address or phone number of nurses whom they had approached.
A letter of introduction was then sent to the nurse who responded by mail or phone if willing to participate (see Appendix C). This method of selection is congruent with a combination of two methods suggested by Diers (1979). The first method is called purposive sampling. Here, respondents who "represent" the topic being studied are selected (i.e., nurses interested in partaking in a study about multiple loyalty conflicts in nursing). Secondly, nominated sampling, a way of asking for names of appropriate individuals to include in the study, was used.

Of the eleven respondents, six had their diploma in nursing, four their baccalaureate in nursing, and one a master's degree in nursing. Of interest, each nurse demonstrated the need for continual learning, all had taken either degree or nondegree courses for personal and professional growth reasons. The average age was thirty with a range of twenty-four years to the mid-fifties. All nurses worked fulltime. Experience ranged from three years to thirty-one years with an average of thirteen years. Eight nurses worked in hospitals and three in community health centres. In the hospital setting, four respondents were staff nurses, one a head nurse, two assistant head nurses, and one was an assistant director of nursing. In the community, one nurse worked in long term care and the other two in the prevention program.

Data Collection

Two, one to one and one-half hour, semi-structured, in-depth
interviews were conducted with six of the respondents and one, two hour interview with the remaining five. Each interview was audiotaped and then transcribed. In keeping with the methodology, theoretical sampling was employed (Glaser, 1978). This form of sampling entails the transcription, analysis and coding of each interview so that pertinent categories of concepts and themes can emerge prior to the next interview. Memos were written and designed to elaborate upon ideas in relation to the evolving structure. Then, in subsequent interviews, data were elicited which either confirmed, denied, encouraged revision, or helped to saturate the evolving categories or concepts. Continual comparison of the similarities and differences in content between the various interviews helped to determine the structural conditions of the evolving categories, relevant boundaries were delimited and, as Glaser and Strauss (1967) suggest, conceptual gaps were made more evident.

Each interview had a goal. The first served as an introduction to the research process and to gain a small amount of demographic information as well as to elicit information relative to the nurse's understanding of ethical principles. Examples of multiple loyalty conflict situations in nursing practice were then sought and the general decision procedure outlined along the lines of the Curtin model. Then, as noted, the interview was transcribed and analyzed. The second interview served to clarify any questions that had arisen (by either the respondent or the researcher) and to seek pertinent,
more in-depth data that would help to identify the level and stage of moral reasoning used in the resolution phase of the decision process. Concomitantly, data pertaining to the reasoning the nurse used to state what should have been done or what would have been preferred was elicited, and any discrepancies between reasons for the performed action versus those for a preferred alternative were noted. Following the twelfth interview with the initial six nurses, certain conceptual patterns and ways of responding to conflicts arose and by that time much of the required data was obtained in a two-hour interview. Therefore, single two-hour interviews were conducted with the remaining respondents.

Data Analysis and Interpretation

Inductive and deductive methods were utilized in the data analysis and interpretation. Inductively, significant substantive quotes were noted and particularly descriptive events demarked for future use in identifying and "sensitizing" the chosen categories (Glaser & Strauss, 1968, p. 24). Deductive methods were utilized both to compare and contrast inductive results to various concepts and theories already in the literature, as well as to determine how the emerging concepts and themes related to the rationale for the study, or as Glaser and Strauss note, to assess the relevance of the beginning "foothold concepts" (p. 45). However, as Glaser's (1978) warning was heeded, a balance between the two logics was maintained, with the deductive in the service of the inductive.
The continual comparing of the grounded material with the more abstract deductive tended to force the investigator to generate categories and concepts, and to explore their properties, interactions and limitations until saturation of conceptual categories occurred (i.e., no additional data was found which contributed further to the categories) (Glaser, 1978). At this point, a way of thinking about the reasoning process involved in the conflict situation, which was grounded in data, emerged.

This type of analysis incorporated a continual referral to and assessment of patterns of reasoning as detailed in cognitive moral development theory. In addition, core concepts were sought from within the data concepts that would provide a view to the nurse's subjective experience at the time. It was thought that experiences would contribute to some extent to reasoning ability; hence, Crisham's concern with milieu effect was addressed, and as Kohlberg's critiques and then Kohlberg, himself, admitted, the contextual nature of the situation did contribute to variations in reasoning patterns.

**Ethical Concerns**

The rights of the research subject were upheld, confidentially safeguarded, and permission to withdraw from the study at any time, granted. Subjects were also informed that they may refuse to answer any questions. Information which elaborated on these concerns was provided in an introductory letter and a signature acknowledging consent was required before data collection began (see Appendix D).
Potential risks which had initially been foreseen related to the affective domain. For example, it was felt that feelings of sadness, frustration, or anger, might have arisen as nurses discussed conflicts in their practice. It was felt necessary to observe for such emotions and to acknowledge them should they arise; moreover, time was then to be set aside for the subject to verbalize feelings associated with the issue if they so desired.

Limitations to the Study

Concerns related to study limitations are threefold: First, eleven respondents provided adequate data for category development and description of themes, however, a larger sample would have aided further descriptive refinement within each theme; secondly, selection by the method of intraprofessional referral could possibly have provided a biased sample as only those nurses who have problems with the ethical decision process responded; finally, the goal of the interviews was to utilize open-ended questions to promote in-depth discussion, nevertheless, the investigator may not have made sensitive enough discriminations between pertinent and nonpertinent data. With these considerations in mind, the generalizability of the findings is limited.

Summary

An exploratory grounded theory design proved to be effective and concepts and themes which described nursing responses to multiple loyalty conflict were derived from the data. Reviews of pertinent
literature aided in clarifying various properties of each conceptual dimension and helped tie substantive concepts to formal theory. Although the sample was small and thereby generalizability is reduced, adequate data was gathered resulting in a grounded theoretical perspective.
Chapter Four: Data Analysis

Introduction

The purpose of this chapter is to demonstrate how a substantially derived framework of core concepts, categories and themes relates to and describes factors from the empirical data. Firstly, types of multiple loyalty conflict are identified; secondly, the substantive concepts are outlined and linked to cognitive moral development theory. Each dimension of the main concept is then defined, supported by themes and quotes and finally compared to pertinent concepts and theories in the literature.

Part One

Multiple Loyalty Conflicts

Many varieties of conflicts were noted by the registered nurses as they correlated their views on conflict of loyalty situations with their beliefs about patient autonomy. Situations described by the respondents included (a) intrapersonal conflicts with personal-professional ambivalence (i.e., the nurse agreed to a resolution which created some sort of inner personal turmoil); (b) intraprofessional difficulties between nurses (i.e., a nurse views time with the patient as important whereas nursing administration bases priority on productivity and efficiency); (c) interprofessional problems with physicians and social workers (i.e., conflicts between domains of practice); (d) ambiguities arising between duties to the institution versus those to the profession itself (i.e., institutional policy
statements which do not support high standards for nursing); (e) awkward situations with overbearing or uninterested family members (i.e., dealing with relatives who demand certain therapies without consulting their family member, or conversely, coping with family members who do not assist a more dependent member when it is necessary). In many instances, the conflict was based on a question that lay just beneath the surface of the problem: What is an appropriate, fair and just balance between the individual's right to autonomy, the individual's duty to be a responsible citizen versus the reciprocal rights and duties of a responsible society toward its citizens? It is the individual nurse's answer to this question that often seem to contribute to how the conflict is resolved (i.e., to what, within the nursing range of responsibilities, was permitted to happen).

**Substantive Concepts**

An analysis of data shows that nurses tried to resolve multiple loyalty conflicts by seeking ways to promote patient autonomy, however, varying perceptions of relevance hindered their efforts. And the whole idea of perceived relevance, the study's major substantive concept, lies within the notion of individual perception of self and the importance of one's person in a particular situation. The data suggest a three-part categorical breakdown of perceived relevance. This breakdown is based on the respondent's perception of self in the conflict, which contributed to how important nursing input was
perceived to be, to how the nurse chose to cope with the situation and to how the nurse would have preferred to have coped with it.

Evidence to support this categorical outline became noticeable both when the respondents tried to express what they did at the time of the conflict and when they attempted to explain why they made the choice they did. A definite three-dimensional operationalized schema of self interpretation evolved as subjective interpretations provided similar reasons for action even when the content of the conflict situation differed. The dimensions are categorized as follows: The first is based on the perception of inequality or disparity in professional contribution, a second on the limitation or restriction inherent in a complex conflict situation which takes place within an institutional framework, the third on the perception of equality and feelings of accountability.

Substantial support for part of this conceptual schema has been found in the writings of one author in particular, Alfred Schutz (1970). He attempted to synthesize ideas from the sociologist Weber and the philosopher Husserl in order to provide a framework which would support a meaningful construction of social reality or, in other words, phenomenological sociology. Schutz's (1970) writings are found to support the basic idea of this study as he firmly believes that consciousness is tied to concrete experiences. He is concerned with how individuals attach subjective meanings to particular experiences. To Schutz, perception of what
is in fact relevant is based on what is expected or what has become typical in the situation. He defines perceived relevance as the importance ascribed by an individual to aspects of specific situations when the individual's multifarious interests and involvements are considered. These interests relate to domains of relevance. While Schutz lists several such domains, two are pertinent to this study. The first is that of imposed relevance. This means that a particular way of viewing a situation is forced or urged on another. The second domain of value is that of volitional relevance whereby freedom to choose how to view a situation is granted.

Schutz's perspective provides valuable assistance not only in supporting the need to study subjective interpretations of experience, but also in helping to clarify the meaning and to give the labelling of two of the substantive categories: relevance based on inequality now refers to imposed relevance and that based on equality is now volitional relevance. The middle category will be called bounded relevance. Operational definitions, based on a deductive refinement of the inductively discovered concepts, are as follows:

**Perceived relevance.** The view of self as it pertains to the subjective interpretation of the multiple loyalty conflict situation.

1. **Imposed relevance.** The perception of inequality based on a set of firmly held expectations.

2. **Bounded relevance.** The perception of limitations based on the need to maintain relationships or uphold rules.
3. **Volitional relevance.** The perception of equality expressed as the right to participate and to make choices congruent with self chosen ethical principles.

The subjective interpretation of conflict in a concrete situation results in a certain perception of what is relevant followed by the need to resolve the issue in some way and to act. However, when one steps back and reviews the situation, the need to become objective and to seek a more ideal solution is natural. This perspective provides a normative view. In such cases, the subjective world view takes on a lesser importance and pure, abstract, more objective cognition becomes primary. Hence, in order to view thought forms of the descriptive and the normative views together, the three-dimensional nature of the core substantive concept is integrated into the framework of cognitive moral development theory. This inclusion provides a comparative view of the theoretical and the contextual descriptive nature of multiple loyalty conflicts.

**Theoretical Integration**

In order to understand how pragmatic real world phenomena can be integrated with cognitive moral development theory on a two-level, descriptive and normative basis, it is first necessary to explain the manner in which the linkage occurs. As the study began it was unclear just how this theory to practice link would occur. It was not clear just how deeply subjective interpretations would affect patterns of reasoning which contribute to normative viewpoints. For example, Flaherty (1981) notes how nurses have traditionally
based arguments for or against action on emotive elements. Hence, it was thought that nurses would not be objective and there would be less of a gap between the structure of descriptive and normative reasoning than proved to be true. However, respondents were consistently rational and objective when asked to provide a preferred resolution and outcome in conflict situations. In short, when asked for descriptive details, affect and emotion intertwined with cognitive factors. But when responding to questions that elicited normative aspects of thought, the nurses' patterns of reasoning were grounded in the cognitive domain.

Bearing this factor in mind, it soon became evident that the phenomenologically experienced conflict situations could be better understood by utilizing the three-dimensional substantive concepts along with the theory of cognitive moral development to discuss the descriptive case examples and then refer singularity to cognitive moral development categories to outline the normative view. Figure 3 outlines this relationship.

<table>
<thead>
<tr>
<th>Perceived Relevance: Descriptive Analysis</th>
<th>Normative Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconventional</td>
<td>Level and Stage</td>
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<tr>
<td>Stage I, II</td>
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<tr>
<td>1. Imposed Relevance</td>
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<tr>
<td>Themes:</td>
<td></td>
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<tr>
<td>Conventional</td>
<td></td>
</tr>
<tr>
<td>Stage III, IV</td>
<td></td>
</tr>
<tr>
<td>2. Bounded Relevance</td>
<td></td>
</tr>
<tr>
<td>Themes:</td>
<td></td>
</tr>
<tr>
<td>Postconventional</td>
<td></td>
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<tr>
<td>Stage V, VI</td>
<td></td>
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<tr>
<td>3. Volitional Relevance</td>
<td></td>
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<tr>
<td>Themes:</td>
<td></td>
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</table>

**Figure 3.** Structural components of cognitive and affective comparisons.
Part Two

A. Imposed Relevance

At the preconventional level the nurses felt that a selected set of rules and facts were imposed on them and that there was a strong positive correlation between their personal-professional welfare and obedience to these impositions. While nurses had one view of what supporting patient autonomy actually meant to them, they felt forced to compromise their beliefs to the point of consciously agreeing to utilize patterns of reasoning congruent with Stage I and II thinking. Needless to say, loyalties were torn and ambivalence expressed. Themes for this category fell uniformly under the heading of one major principle: The nurses perceived that blind obedience to rule was the most relevant factor for all decisions. Promotion of patient autonomy, while at times attained subversively, became a third priority: first priority went to obeying rules (both overt and covert); second priority to self protection; and third, to the patient. Themes of anger, resentment, and revenge followed as nurses tried to cope with a highly compromised sense of professional integrity.

In the examination of specific cases it can be seen how patterns of reasoning reflect each of the above three themes and how the patterns of reasoning change when objective consideration is given to how patient autonomy could have been promoted.

Several of the worst examples of unprofessional behavior and
most blatant neglect of patient welfare occurred when professional relevance is placed secondary while unjust rules of "correct" behavior take precedence. The first episode occurred in a critical care unit. It depicts the theme of anger and shows how the nurse could not protect her patient's right to adequate medical treatment.

**Theme: Anger**

**Case #1**

**Descriptive analysis.** A patient had a severe cardiac conduction problem and was in need of an AV sequential pacemaker. At present the ventricle needed pacing; however, it was felt that before long the atrium would need pacing as well. A surgeon who has a reputation for drinking was called in. The patient was informed of the conduction problem and consented to having an AV sequential pacemaker installed. The surgeon arrived in the operating room inebriated. Although he had performed surgery in that operating room before, he could not find the theatre.

*R:* He apparently was smelling of alcohol . . . one of the OR nurses had to lead the doctor to the operating room. And this was witnessed by the representative from the company who spoke to me about it because he was quite upset.

At this time the pacemaker representative also told the nurse that he had asked to go into the theatre with the surgeon so he could explain how this newer pacemaker worked—this is the usual procedure when new equipment comes on the market. The surgeon refused.

This nurse, who was now caring for the patient, knew that initially the leads to the pacemaker had been connected up backwards
and the patient had to return to the operating room within 24 hours for another anaesthetic. Yet, still the atrial lead was not connected up properly. So on the third day the director of the unit had to decide whether the patient should have a third surgery or whether the atrial lead should be shut off.

R: What the director decided to do was to turn off the atrial portion and just leave the patient with a ventrical pacemaker, so what it means is that she has a wire in her heart that is functionless and that if she ever needs atrial pacing they will have to operate again and put in a new atrial lead and it is just not a happy situation because it is a pacemaker that costs a lot of money.

I: What is a lot?

R: Twenty thousand dollars.

The conflict between promoting the rights of the patient and dealing with a set of facts that state, the physician is right, proved most difficult. Not only did a nurse lead the inebriated physician to the operating theatre, but also the critical care nurses noted that he was "smelling of alcohol" and reported this to the head nurse.

I: It was reported that the man was inebriated two times?

R: Yes. I encouraged the representative of the pacemaker company to tell her this.

I: It was the representative of the pacemaker company that had to tell the director of the unit?

R: That's right.

I: Not the operating room nurses?

R: No. And also the director basically said, after the pacemaker representative left the unit, "I'll never use
these pacemakers again, there must be something wrong with them." But there's nothing wrong with his pacemaker. What's wrong is the person the director has putting them in—the director just won't admit that.

I: The director won't admit it but the pacemaker representative did say that the surgeon was inebriated?

R: Yes, he did.

I: And the response was to deny the fact?"

R: Hmm.

I: Just deny it?

R: Yes, just nothing. And in the meantime we had documented this for the head nurse, right, that he had come in—

I: Documented, how?

R: We have a report that is called a nursing practice form.

I: Okay.

R: And it was given to the coordinator who ripped it up.

I: The nursing coordinator? Why did she rip it up?

R: Because she said that the solution recommended was inappropriate.

I: What about another form then?

R: Well, apparently, it was going to be followed up but we've had no—no one has ever come back to us and said that it was looked into.

I: But the point is that the formal complaint was torn up.

R: That's right. . . . This form is a nursing practice form. . . . We are actually reporting medical practice, and we have no real form in our hospital to report medical practice.

I: Do you think you should have one?

R: I think so, yes. I think not to be vindictive or anything, but I think there are times when nurses witness things that
are clearly negligent or incompetent or we see a physician practicing under the influence of drugs or alcohol and we have no protection. Because who do we complain to? It's hard to complain to the medical director who is not there to see things. It's your word against the physicians. You can't complain to the physician's association because again it's their word against your's. . . . I think sometimes that there is a real moral and ethical issue in terms of there are lots of times when I feel like I would like to tell their patients and their families.

I: Tell them what?

R: That they have suffered grievously at the hands of an incompetent physician. Their physicians have admitted error.

I: To?

R: To another physician. But, they won't tell the patients, so the patient goes home never knowing how his case was screwed up. But we can't do that. It's unethical for us to do that, to go and tell a family, you know, this doctor really screwed you around.

So here we have anger directed at the system which protects such behavior, and sorrow because when patients ideally could be warned the prevailing rule makes such a warning unethical.

When asked what she would have preferred to see happen, this nurse stated that a proper form should be devised and, as well, the operating room nurse should have called the nursing supervisor to come attend to the surgeon. Plus, of course, further action was demanded of the head nurse. Because of this and similar activity, the morale in their unit is low and nurses face continual conflict when they attempt to deal with it.

R: Nurses have discussed the problem at length and have discussed it with the head nurse who has attempted to discuss it with the director involved. But it doesn't—there is no resolution because this physician hasn't a
terribly high regard for nurses. And I mean, we have a new head nurse almost every year because of this. This means there is obvious conflict, you know, really obvious. And the fact that the physician doesn't see this as a problem is a problem.

I: What would you prefer? Is there any route to resolving this that you can see?

R: Yes, I think there is a route but it is not an immediate short term answer. It's a very long term route and I think it relates to nursing itself as a profession, you know, ... about nurses being women and how they express themselves, how they communicate because they are women, how they exercise their judgment within the power structure, how they try to affect change and fail because they don't go about it properly. I think it has to do with the credibility that our profession has not established for itself because we are not recognized as having a body of knowledge that is independent from medicine or being a discipline that is independent from medicine. And I don't mean independent all the time because some of our functions are interdependent, but, you know, just being an entity of its own. I think the fact that nursing has no power in many health care systems, power to be involved in significant decision making, we're always affected dramatically by decisions but we are not usually at the hub of the decision making process and that involves nurses becoming more political and getting more control of the decision making process that affects their lives so dramatically. Boards of Directors of hospitals seldom have nurses on them, yet what are hospitals for if not for nursing? ... Hospitals should function for nurses and nurses should be the prime decision makers.

She goes on to say that rarely do Boards of Directors show adequate representation.

R: Two of the main interests in the hospital, the consumer and the nurse, are not represented—that has a great impact when it comes to allocation of funds and when it comes down to even just the respect that is accorded the nurses in the hospital and the respect that is accorded the patients or users of the hospital.

I: So you are saying that a whole attitude change is necessary before nursing could have something to say to that physician director?
R: Yes, because as it is right now in our hospital, the medical people can interview for selection of people for nursing positions but the nurses don't interview for selection of medical people for medical positions, so there is a clear superiority situation set up where one has control over the other, where one affects very much the life of another without really having a great knowledge of what the other even does. You know, I think there are a few doctors who know what nurses really do. The same thing applies at the political level, but much higher in our government where you have health care planners who plan health care but don't take the advice of the people in health care all that well. You get the white paper on health care that was generated by the Hall Commission. How long ago was that and yet we haven't really seen any concrete evidence that there is a change in our political allocation of funds in health care to preventative work, or to community work, where there is even a desire to save money by allocating funds to less costly forms of treatment. And I'm talking about all holistic things, all preventative programs, or using nurses as an access to the health care system. Clearly, the lobby is in from other groups which prevent this from happening. So nurses are not represented well enough at the government level and by saying that the director of our professional association meets with the Minister of Health twice a year to discuss certain issues causes despair for me, it's not even funny. It gives me despair because what that means is that we are not an active participant in the decision making process.

I: That is really an interesting answer because what you've done is you've taken the problem right in your unit and you've built it into the broader hospitals and the broader provincial political scene to the national scene. So that kind of problem is really, I gather, a typical one in nursing?

R: We've just had a staff meeting about the morale in our unit lately because it is very low and I might add that that's not unusual.

I: In your unit—

R: It's not unusual in my hospital. I think the morale is generally low among nurses really, the ones that I know are not happy with the profession for one reason or another and most of them state that it is not the job per se that makes them unhappy, it's the conditions and the communication
and all those other externals that are a part of your job and affect your life dramatically at work. I just sort of laugh when my head nurse says that we are going to solve the problems of morale at our staff meeting because we don't have any control over the things that get us down; you know, I think that's it really. I think there is a certain amount of your own attitude you can have control over and to be fair, you can be positive and try and struggle for better working conditions and so on, but, on the other side of that coin, when you are already giving so much of yourself, there is not a lot left to have to deal with all those external stresses too. The external stresses are the ones I think that are really hacking away at nursing right now. It's making it a less desirable profession. It's making the nurses leave. It's making nurses not come in, you know, potential nurses, because it's a job in which you don't have any control over your own destiny, almost. You're there and you're at the beck and call of the system and your life is not your own. You know, even your off duty life is not your own because you're subject to callback and the working hours are so terrible with shift work. Having to work rotations of seven or eight days or, worse yet, regressing to twelve-hour shifts which—the labor movement has struggled for years to get people out of sweatshop work hours of twelve hours a day down to decent work hours. Nurses have regressed to that out of self defence so that they could have some time off away from their job. It shouldn't have to be that way and I think that the fact that it is allowed to happen bespeaks first of all of the respect the nurses have for themselves and, secondly, to the respect that society has for nurses. And so with all these externals, how can the nurse have control over her working situation?

I: So you think that it is hopeless, almost, to change the morale?

R: Yes, I do. I think that the best that a nurse that I work with can do today is she can say, "I am going to go to work and when I'm at work I'm going to do the best job I can do for my patients and hope that nobody gets in my way." And if somebody said, did you have a good day or a bad day, to me, a good day is when I am allowed to go to work and do my job as I see it without getting hassled.

Normative analysis. This nurse in a most eloquent monologue voices the issue most clearly. What should or could have been done
is backed up by Stage VI thinking. This nurse is aware of the rights of consumers and of nurses. She is aware of the social contract nurses have made via the nursing Act and expressed in the nursing Code and Standards of Care document. She sees the need for nurses to promote and protect their rights so that, in turn, the rights of the patient can be upheld. A certain utilitarian perspective, a trait of Stage V reasoning is noted when she states those who ought to benefit by the health care system are the consumers. This, she says, includes us all; therefore, the health care system should benefit the consumer first. She pleads for fair and beneficial practices.

But caught by the relevances of the milieu situation she not only continues to care for a patient who has an inebriated surgeon, she is unable to do anything when the nurses' complaint is torn up and the surgeon returns to perform the second surgery. Pragmatic concerns based on self interest led to a pattern of reasoning at the time that is classified as Stage I because the nurse did not want to deal with the wrath of a controlling authoritative director.

The second case, depicting similar reasoning, brings up an example of how severe the pull on loyalties can be when tension exists between promoting what a patient desires and protecting oneself in an unsupportive environment.

Case #2

Descriptive analysis. This incident occurred when a nurse from another agency was observing a caesarean birth in a health care
institution. Background factors revolve around the desire of the prospective parents to see their baby's birth: the woman had requested an epidural anaesthetic and the physicians involved had agreed.

Prior to the actual initiation of the anaesthetic several facts which would influence this case require mentioning. The obstetrician was to be thirty minutes late. With this in mind, the general practitioner "who was in a hurry" continually urged the anaesthetist to administer the epidural. The anaesthetist firmly refused stating that it was against hospital policy to administer epidurals before the obstetrician was in the theatre.

R: So we were about ten minutes late and we got a phone call that the obstetrician was on his way but it would be ten or fifteen minutes yet. And so again the family physician kept pressuring, "come on, give her the epidural, let it take effect so that as soon as the obstetrician comes we can get in there." This was kind of on the sidelines because the woman was awake and the husband was there as well. So the anaesthetist kind of ignored him and then said, "No, I will not do that." So eventually the obstetrician arrived and she was given the epidural right away. Well, it was either slow to take effect or it wasn't taking effect, so they gave her a second dose of the epidural in about ten minutes when they realized nothing was happening. And they were, both doctors were, the obstetrician and the family physician, were still in a hurry so without waiting to see if the second epidural was going to work, or had worked, they incised her!

I: Incised her?

R: Incised her and she is awake and feeling and screaming with pain. And the clinical nurse pops her head in the door to see what was going on and she whipped the husband out the door right away when she heard the screaming. And then all I could hear was both doctors saying, "Get her out, get her out, quick, quick, quick." So the anaesthetist then administered the mask to give her the general anaesthetic. And as she was going under she was still screaming at them,
"No, no, I want to be awake, wait, wait, I want to see my baby born." And she was out.

I: Even when she was in all that pain, she was still saying, "wait, I want to see my baby"?

R: "I want to be awake, I can stand the pain, I want to be awake." . . . She didn't realize that they were doing a very wrong thing. But I did and so did everybody in the room. And I was absolutely horrified. I was just sick to my stomach and I watched the nurses and I couldn't understand why the nurses were, you know, why they didn't say to the obstetrician, "no, wait ten minutes," or even to the anaesthetist, "wait ten minutes to see if the epidurals will work." Why they didn't say, "no, stop." But it was like a conspiracy almost.

I: To go along with the doctors?

R: Yes, the doctors had the power and everybody else went along with it. I was just so angry and just so confused and livid. The doctors were so cold and in a hurry. I was really shaky after it was all over and I thought—my ethical sense said, "I should tell this couple that what went on is totally unethical."

This nurse did not do this. She reported the incident to the nurse clinician at the institution. She reported it to her immediate supervisor and to the two supervisors above the first one. Finally, the nursing director of the agency where she was employed had her write a letter with the details and send it to the institution in question. Before this letter was sent, (a) the nurse had to rewrite the letter several times to "soften the tone" of it; (b) the medical director of the agency had to review it and suggested that the College of Physicians and Surgeons be notified, but the College refused to speak to the physicians; moreover, (c) the letter was not addressed to the administrator or director of nursing but to
the clinical nursing specialist of the unit. An answer concerning followup was never received.

This nurse is angry and still somewhat horrified as she relates the event three years later. When asked what she would have preferred, she made this statement.

R: I wish my thoughts and emotions had been together enough so that I would have spoken up and said, "Stop," you know, "Why do you want to cut her when you haven't waited for the epidural to take effect?" I wish I could have been collected enough to say that right then. I would certainly have caused a commotion and I probably would have been thrown out. I believe that this husband and wife read books, asked questions and knew what they wanted. Well, I handled it the proper bureaucratic way, but I am still angry.

This nurse did check several times over a number of months to see if mother and baby were fine. They were.

Normative analysis. In this case as well, right became Stage I blind obedience to authority because the nurse's intent was to avoid punishment. She knew she would not be supported if she had taken a professional stance. Several implicit rules were obeyed here: (a) do not interfere with the physicians even if your "ethical sense" tells you to; (b) do not inform patients of their right to quality care if it has not been maintained. The nurse felt unequal. Numerous very powerful implicit guidelines directed her behavior.

Nevertheless, with opportunity to reflect, Stage V thinking is evident. She felt a duty and an obligation to uphold the rights and hopes of the expectant mother and father. She felt that they
had made an informed choice and that their decision should have been respected.

In the next case, right becomes relative; instrumentally speaking, the nurse has to get along with others on the health care team. She perceives herself as unequal but capable of at least trying to organize a degree of fair exchange in the sense that, although unequal, she is a needed participant. On this basis, she tries to provide support for families in need.

Case #3

Descriptive analysis. A member of a family was dying. The nurse was making rounds with the family doctor, "who just comes in and out of the situation and is not heavily involved in it." He said, "Don't tell the family [he is dying], they are not ready for this yet."

R: We nurses have seen the family every day for the last two weeks and they are sitting there in absolute anguish wondering what is going on. I recommended that the not-telling approach is not very feasible, but my statement was ignored. They [the doctors] don't pick up on anything they don't want to pick up on. People who shirk these kinds of responsibilities shirk them all along the way—they won't pick up on these things.

I: What happened to the family?

R: Hmm.

I: Would someone tell them, a doctor, a nurse, or would they be left longer?

R: Oh, easily. Their anguish affects nursing a lot more than it does some aspects of medicine.

I: How does it affect them?

R: How, in that the family practitioner, at most, may see this
family three minutes a week. We nurses see the family—in a twelve-hour shift you see them for six hours. Each case being different you know. Did we let this family sit in anguish? Yes we did. Again though, if the family comes in and asks the appropriate questions, you can introduce subjects which will alleviate some of their anguish.

I: What kinds of subjects would you introduce?

R: Hmm. Are you wondering why he isn't breathing on his own? You know, is this something that concerns you? By their responses you'll know if they want a simple answer or an indepth answer—you start out simply and meet their needs.

I: Why would you introduce such questions?

R: It is so obvious. They are there and they look to you. They present themselves in a state of anxiety and worry and horror at what is happening. You are there looking after their family member and feel quite responsible for what is happening.

I: For the family, too, you mean?"

R: You feel responsible for the patient and the condition he is in. I mean—this is a person who is significant to someone else. I don't see them as separate.

In this case, the nurse perceived the family had a need to know; nevertheless, telling becomes a covert questioning and answering process. The nurse exclaims in anger, "Why go through hell when you don't have to!" "When simple knowledge and understanding will put you at ease for a bit, I think this is the least people deserve."

The nurse interpreted what was right by how the family responded to vague hints she gave and the physician interpreted right from information gleaned in short weekly visits. When asked what she would prefer, this nurse made the following response.

R: I think, generally speaking, nurses should represent the human factor. Nurses are the "state of the art." We are
the ones that encourage the medical personnel to be more human. Seeing doctors as a support system for nurses hasn't been one of the things I've observed or with the patients. For example, to recognize that this patient is a human being with a family with problems with needs for interaction—we present this to the doctors who care about it.

I: You choose who you present it to?

R: Oh, absolutely. Some are too busy. There are lots of times when that really is true, too. It's just that those who really care go through a lot more anguish about being too busy than the others who will deliberately be too busy. But the nurse needs support if she is to remain humane and empathetic and to deal with her feelings. I see absolutely no support for the nurse in that role. I think that is just bluntly it. You bring with you, as a nurse, what you are, whatever your history has been. There were some nursing instructors who had the capacity to encourage the element of humanity. Though, it also comes with growing up, experiencing a lot of things yourself. Perceptions change. It's through growth. And as the humane aspect grows I think the quality of nursing grows too.

**Normative analysis.** Stage II patterns of reasoning are evident here as the nurse explains how she copes with this kind of conflict. She arranges a question and answer session with the questions geared to subtly test the family to see how she can best meet their needs for information—how she can best relieve their anguish due to not knowing. But the nurse is angry about this because she realizes how chance and luck are reflected in how a family is treated. She also notes that, "Many nurses withdraw from this dilemma by not becoming overly involved in the human factor." She says that this nurse "does her work, provides cursory news of the days without inviting anything else—this keeps her emotionally stable."

Nevertheless, in her statement of preference, she speaks with Stage IV
patterns of reasoning. She believes that nurses should remain humane helpers seeing patients as human beings in need of sustenance, support and information. Desirous of maintaining the system with nurses who can provide such care, she asks for support for nurses.

Each case represents a typology of incidents which depict the dependent and unequal nature of the nurse's perception of her role. These nurses responded with anger. At times, though, this same perception of inequality in relevance led to the themes of resentment and the presence of feelings of indignant displeasure.

**Theme: Resentment**

Providing an example of how resentment forms, this nurse outlines the steps in the process. She has observed what happens with staff nurses who initially try to promote what they believe is necessary for their patients, yet are defeated by the system. Moreover, this nurse herself, though on a broader level, voices resentment. She believes that nurses must learn to function as professionals before they will be able to assist patients to voice their own decisions or provide adequate care for the dependent patient.

**Case #4**

**Descriptive analysis**

**R:** Nurses say to me, "Call this physician for me." I say, "Why?" The response is invariably, "I don't want to call this physician because the last time I called, he was mean." The nurses seek about until they can find someone to call for them.

**I:** Is it because they feel they've been mistreated at some point?
R: They feel they have been. Of course it depends on the emotional maturity of the people [nurses] involved.

I: In other words you need people who are mature and will continue to call.

R: Yes.

When asked if these other nurses will call, she answered,

R: Oh, they'll make the call if they absolutely have to, but it's not made with a good tone of voice. Do you know what I'm saying?

I: Are they almost setting themselves up because they are resentful?

R: They are ready for him to yell. A lot of nurses bear grudges because the nurses may make a suggestion and the doctor basically tosses away a suggestion which shouldn't be a suggestion—it should be prudent medical treatment at this point in time. And as far as I know, he has no reason to do that. That's the kind of thing that prevents nurses from taking the risk the second time. I think that's why a lot of things get left.

At times, she mentions, nurses will put their request in writing.

R: I try to get them to sign their notes, sometimes they don't, but it then certainly has a degree of anonymity to it which offers them a comfort zone.

I: So a comfort zone comes from writing an anonymous note.

R: So he can throw it away—it's not as embarrassing to them.

I: To the nurse?

R: Yes.

I: In general, when that happens, do the physicians just not want nursing input, or is it that they don't agree with the suggestion?

R: It depends on the physician. There are some who do not want nursing input. They are the paternalistic Gods and they know what to do. And there are some who wouldn't know a good suggestion when they hear it. And we do have
a fair number of family practitioners who fall under that category—some because they have been practicing for too long without keeping up.

I: Are you saying, that because they have not kept up, they wouldn't recognize a good suggestion?

R: Yes. When it is something that is really going to influence patient care, I go the medical management team. This team has the ability to put pressure on doctors.

I: They listen to nursing?

R: Yes, and we usually get the kind of results we want in 24 hours because I think a lot of times when a family physician is phoned by the team, they know they've done it. It's not because we haven't talked to them. It's not because we've gone right over their heads. We've probably been asking them for a week or so for something and we're not getting anywhere.

I: But, previously, you mentioned the backlash that can occur?

R: It will if the doctor goes running down to the nursing administration, to the coordinator or assistant directors. I think they often see their jobs as being to placate. I think nursing administration should be less willing to placate the doctors and should be more willing to find out what is happening on their units. In fact, I do not go to nursing for support for my decision making, I go to a really good group of physicians. But in the end, you have responsibility to yourself so that you can go home and sleep at night.

I: That is your priority?

R: That has to be the ultimate priority. The ultimate priority is that you call the shots the best way you can. You do what is the most right at any given point in time according to your perception and according to the facts that you have.

I: Because you feel that living with yourself is most important?

R: I think that in the end, that's got to be what it comes down to. Because other people are all going to go their own way and live their own life and if they leave you a battered wreck, they don't care. . . . In nursing, though, emphasis must be put on patient safety and nursing competence.
with patients given as much decision making power as possible. But nurses are indoctrinated into the medical profession—nurses follow doctor's orders. I think some of our nursing leaders are very small minded—which makes me feel sad. Nursing should be taking quantum leaps. Nursing should be knocking down some of the boundaries—making it an absolute profession. Nurses are not going to do that under the present system. They are not going to do that unless they are willing to take on some of the hassle of change.

I: Do you think nurses are willing to do this?

R: Well, I certainly think some of the higher level nursing administrators are not. We are an unaccepted profession. Part of it is because we are women, part of it is because of the nature of the work we do, it is nurturing. And that is traditionally seen as a woman's kind of role—we're just not accepted as professionals. Still, it's great for nurses to want autonomy, it's great for nurses to say all these things—but they do not want to live up to the expectations of it—so it frightens a good many nurses. I think that's why I see two groups of people [nurses] arising because there is a group that will not cope with professionalism, and that group will be at the bedside in the end. They won't have to think and they won't have anything to do except orders—they'll just do. The responsibility won't be on them. It will be on someone else.

Normative analysis. Analysis, in this case, proves somewhat complex as the nurse is functioning at a much higher level of reasoning than some of her staff. Nevertheless, this example of staff nurse behavior provides insight into how resentment forms. These nurses have tried to promote high standards of care for their patients. They just become unwilling to cope with derogatory remarks and ignored or torn-up suggestions. With typical Stage II reasoning, they attempted a fair exchange and, in fact, continue to do so to a point; however, they serve their own needs by leaving a lot of
things, by not following through to the physician. They bear grudges, form resentment and, at times, make phone calls with a tone of voice that suggests they already know they will be treated unprofessionally. There is a perception of inequality. Similarly, on a broader level, this nurse shows resentment towards the nursing administrators and nursing leaders. She believes, for example, that the nursing administrators placate: again, this is a Stage II pattern of behavior as it seeks instrumental gains and deals are made. Showing signs of Stage VI patterns of reasoning, this nurse has definite principles of fairness and justice which guide her behavior. Also, she is quite adamant that the status quo within nursing should change. She wants to see the rights and values of patients respected as well as the nursing profession evolve to a point where not only is it respected, but also it can freely promote the rights of the patients.

One further example of the theme resentment is evidence as one nurse tells how nurses "constantly make compromises with their own ethical stand." In the succeeding case, the advocate for an incompetent patient, his wife, could probably have benefitted from nursing support (i.e., an informed nurse would have been able to discuss her husband's condition and alternate options for care with her).

Case #5

Descriptive analysis. The background for this case involves an elderly dying gentleman and a physician's suggestion to the patient's wife that tube feeding be stopped.
R: The man was unconscious, had no brain and we were keeping him alive for what? The patient's wife became outraged and compared it to Dachau.

I: She is outraged at the doctor's suggestion?

R: There was a time when the doctor would never think of making a suggestion like that.

I: Where does the nurse stand in this case?

R: Exactly, what if the woman had decided the doctor was right and the doctor could discontinue the feeding tubes and stop feeding the patient?

I: If you were in that situation, how would you handle it?

R: I'd have to think about it. Death is not the worst thing that could happen to that man. He had died a long time ago socially speaking.

I: So in this case, you say, nurses would have to really think about it?

R: The nurses didn't think about it.

I: Oh, the nurses didn't think about it?

R: Hmmm.

I: What did they do?

R: The nurses, just for self protection, do not come to terms with anything until the problem is actually their's.

I: Right there, on the unit, in a doctor's order?

R: If the doctor had taken the tube out and said, "Don't feed him anymore," then, we would have had to deal with it. But while he was still asking the wife, it was not our problem. When asked what the nurses would have done had the order been written, she felt that they might have gone to the hospital lawyer or refused to look after the patient. But most likely they would have "deferred to the doctor's order."
R: Nurses are always constrained by doctor's order. . . . For instance, this doctor did not consult with nurses and . . . didn't ask anyone else how they felt about it.

I: Do you feel the nurses should have been part of that decision?

R: I believe that decisions like that are society's decisions. They are not the prerogative of a profession. And as far as the law goes, it reflects society's decisions and it is dangerous not to observe the letter of the law. And I think the tube feeding isn't covered by this.

I: So there would have been a real dilemma for you if the wife had agreed to have the tube removed?

R: Yes . . . because I would have seen it as a dangerous precedent. That withholding food or other kinds of care would become common practice for whomever it is determined is unable to live a complete life. What if there are disagreements here? Instead of going to Siberia, you get your life support system removed.

I: But right now, for this patient, if the order had been written, do you know how you would have dealt with it?

R: No, I don't know how I would have dealt with it. Dealing with authority figures like doctors—

The nurse was asked if this authority hindered support of patient autonomy, or, in this case, the autonomy of the wife. She replied,

R: Definitely. We don't have the autonomy of the medical profession to counter if we disagree or if we feel that there is conflict between the patient's autonomy and the doctor's order. The nurse would have to challenge the medical profession and that is hard to do.

I: It's definitely a feeling that it would be a challenge?

R: Definitely.

I: Not sort of a cooperative discussion, a team approach?

R: I don't think so, nurses aren't called on to discuss things. Nurses are given doctor's orders.
Normative analysis. Although Stage IV reasoning is evident in the preferred approach, this nurse admits confusion over the issue of tube feeding and would have most likely followed the doctor's order even if he had ordered that all feedings stop. Stage I reasoning is evident because this nurse perceived herself as unequal; she felt the authority of the physician could override her protestations. Yet she was very clear in her statement concerning what ought to take precedence. Society's sanction and legal stipulations are needed to provide guidelines. With certain Stage IV reasoning, she acknowledges the need for people in general to face the issue, for legal parameters to be set, and then for the health care system to adopt these guidelines with more than one profession in control of the outcome. This view is geared to protecting and maintaining consistently high standards of care within the health care institutions.

In these examples it is evident that resentment builds when nurses feel that they are faced with situations that emphasize their inequality and are, in addition, unfair. When these conditions become exacerbated, the need to retaliate comes forward and is expressed in the theme of revenge.

Theme: Revenge

Revenge or the need to avenge or retaliate in kind and degree is identified as the main theme in two rather extreme examples. In the first case, the nurse had to cope with something she perceived was highly unjust which caused her to feel the need for revenge.
Her perception of inequality led her to view herself as helpless in a tragic situation.

Case #6

Descriptive analysis. This particular incident involves a young woman who was unaware of aspects of her medical history. The medical and nursing staff, however, were cognizant of her complete medical history.

R: [This woman] had had a breast removed six years before for cancer and was [now] coming in for a hysterectomy for cancer believing it to be a recurrence of her first cancer. In actuality it [the breast removal] was a mistake by the medical professional who had removed the breast.

I: You mean, it wasn't a cancerous breast?

R: It never was cancerous. But because it was a traumatic thing for her, she was told it was cancerous. This was all in her history and it was her uterine cancer that was a primary. It was not secondary as she thought. So what are [nurses] doing in that situation? Do you leave well enough alone? Now where does the nurse's duty lie? Are you going to make her mad for all those years, or are you going to forget about it so she can get on with her business of licking this cancer? . . . But you see, if it was me, I would want to know. I'd want to be mad and I'd want to have first choice of a suit. That might help me lick my second cancer—revenge.

I: Did she feel, this being a secondary, that she was worse or better off . . . because it was a secondary [to her]?

R: You can only just imagine what you would do. I would sue the whole place if I found out they had been keeping this from me.

I: Has she ever found out?

R: No. But to tell her, for instance, that her breast cancer hadn't been cancer and the doctor made a mistake when he hadn't even done a biopsy—he just lopped her breast off and then did a biopsy.
This nurse had initially spoken of opportunities to be untruthful when unable to uphold the patient's right to know. So the interviewer asked,

I: So you were having to act, in a sense, you had to be untruthful?

R: Well, I think nurses have to remember that they have a vested interest in the institution of healing and when truthfulness comes in the way of that institution, then there is going to be hard choices to make and they [nurses] will probably side with the institution that is providing them with a job, or credibility.

I: You feel in your nursing practice that you would have to do that?

R: Uh huh, . . . to a limit. I suppose everybody's got their limit.

I: Could you imagine where your limit would be drawn?

R: Well, I'm saying that this is one instance—I didn't tell her her history.

I: You were protecting her?

R: She could have felt betrayed if she had known at this point—it was being kept from her. I rationalized [that] it was good for her not to know and it was good for me not to tell her that—it was clear incompetence.

I: And you were okay with that?

R: I lived with it.

I: Did you feel that the institution and the physician approach takes precedence?

R: Definitely.

I: You have no doubts?

R: No.

This nurse was asked how she would like to deal with patient histories.
R: I would like to have the chart at the patient's bedside. They would see all reports as they come in and then decide who they would like to discuss them with. There are too many secrets with physicians. Very often histories that are known to the staff are unknown to the patients.

But she adds,

R: I see patients wanting to be taken care of. I see them very happy to relinquish their responsibilities. They actually resist autonomy.

R: Yet as patients become more autonomous, then nurses are more free to creatively help them become autonomous.

I: In your practice, you're not seeing patients demanding rights, demanding information?

R: I offer them their rights. I say, "You tell the doctor what you want to know. Write it on a piece of paper." They say, "Oh, he's so busy. I don't want to bother him." They are afraid that if they state their rights, the doctor will not want to work with them. They believe compliance is the answer to care, to be good, to make sure they have care.

Normative analysis. This is another example of a nurse perceiving nursing relevance as unequal. Others decided that the incident should be covered up so that the patient "wouldn't feel betrayed." There was no long term concern with the patient's psychological state and the meaning to her of what she believes is a second cancer, nor was there concern with her right to know and the relief that may have gone with knowing she hadn't had cancer of the breast. Yes, perhaps she would feel sorrow over the loss, but also relief that it was not malignant. Plus, as the nurse remarked, monetary compensation may have afforded much needed financial support. This nurse cooperated, she feared repercussions so she rationalized the situation away and followed a path congruent with Stage I reasoning. The superior
power of the authorities overruled in the milieu situation. Nevertheless, on reflection and away from the situation, while ready for revenge, this nurse voiced concerns congruent with Stage V reasoning. She felt patients should be informed and should accept some personal responsibility in caring for themselves; thus, even if they chose not to be informed, the liberty to become so ought to be available (e.g., the chart at the bedside), and the liberty to sue if genuine damage has been done ought also to be the patient's choice.

The next case involves a nurse who, in trying to uphold the rights of her patient, actually took a form of revenge.

Case #7

Descriptive analysis. In this case, a 45 year old woman was dying of cancer.

R: She had cancer of the lung and she was in such need of oxygen that she was going a bit crazy. . . . One of the surgeons decided he was going to do a lung biopsy. The anaesthetist said he would not anaesthetize anyone in that condition because he would not be able to get them off the respirator. And she had been without anything to eat or drink for two days while they were arguing about this.

I: Did she have an intravenous?

R: No. It was just—"she's going to have surgery and NPO." So I'm worrying about this and two days was my limit for letting her go. The surgeon and the anaesthetist were sitting in the nursing station arguing. So—

I: Arguing about?

R: The surgeon wanted to do the operation, the anaesthetist said, "No, I'm not going to." And another doctor was in there and everyone was putting in their two cents. So I went down to see her, she was sitting up talking and delirious. . . . She was very hungry, her mouth was sticking
together and all this—and she was begging for water. . . . So, instead of going up to these doctors and saying, "make up your mind or I'm going to feed her right now," I just did it. You know, I chose—well, as I'm thinking back on it now, it was the reaction of a child. You know, you just don't think about it, you just disobey. So I took in a load of jello and juice and gave it to her. I didn't say anything to the doctors. Then the doctors went in to have one more look at her and saw her eating and they came back fuming and screaming, "Who gave her something to eat?" And, of course, I said, "Well, I did." They didn't believe anyone would admit to it right away, so it took them back two steps. "Ah, why did you do that?" And I said, "She was hungry and she hasn't eaten for two days." But I should have gone further and said, "Because you guys can't make up your minds—you don't ask her—you're not asking her family—you're not telling her the risk." So the anaesthetist, I suppose, either agreed to do it, or he said he wouldn't, and they found someone who did. So she ended up being bumped to surgery the next day.

I: Did she sign a consent?

R: Now, I can't remember that. She could have signed it before. And she probably wouldn't care what she signed. This guy wanted to go in and do a lung biopsy, well, I don't know why. So he went in and got her lung biopsied—and they couldn't get her off the respirator. That was a sad case. I was sorry about the whole thing and she certainly didn't have any input. I think the guy [the doctor] needed a case in the operating room. And he was aggressive and pushy and he bullied the anaesthetist to the limit and he got his way. And it wouldn't matter if she was NPO four days, he'd keep her NPO until he got his way. So he was furious when I fed her.

I: What would you do tomorrow if that happened?

R: I'd make sure the patient knew what was going on. And if the patient was delirious, as she had become—she couldn't have made a decision whether to go to the operating room or not. Then I would say, you have to involve the family.

I: Why would you choose to be more autonomous now?

R: Well, I think that you have to go through the bad experiences to make your decisions. You know, you have to actually experience poor decisions to give you a feeling for where
you ought to be. There isn't any structured position for nurses. They're on the fringes of everyone else's decisions. They're required to follow doctor's orders, you see. That's how we are trained. Yet on the other hand, we are told to question orders we don't agree with. But you do that discreetly. I think that case haunted a lot more people. The anaesthetist should have known that other people would have supported his decision. The nurses should have been in on that decision. To point out how nonpersonal nurses are—they were having their argument in the nursing station [as if] we weren't there! I hadn't worked it out in my head [first]. I reacted, I didn't act.

R: Part of the problem—I think a great part of the problem with these ethical dilemmas is that there is no place for nursing decisions—there really isn't. They can tell you there is and there really isn't. The one making the decisions is the doctor—the patient either writes a consent or says no. And then you're the one supposed to coerce the patient into signing the consent if you are a "good" nurse.

I: Would you coerce now?

R: Never, never.

Normative analysis. Issues of imposed relevance grounded in the authority of others reinforced the perception of inequality and radically altered the nurse's belief in quality care in this case. The nurse, as she states, did not know how to act so she reacted. In taking revenge, she tried to be fair to the patient as well as to meet her own need to provide food and fluid to a dehydrated patient. She did not wish to follow the authoritative point of view, yet was unable to make her preferred stand. She responded in an admittedly childish Stage II manner. She now, true to Stage IV patterns of reasoning, would take a firmer stance by stating the nursing perspective and asking for the family to be brought in and for a decision concerning hydration to be made.
Preconventional level approaches based on the perception of imposed relevance led to nurses viewing conflict issues from a very concrete individualistic perspective. The nursing concern balanced self interest with the expected consequences before any given action. In this way, untenable risks are avoided. Nevertheless, because the nurses were capable of conventional and postconventional thought and because it was the contextual nature of the social situation that forced regression of thought, they suffered cognitive and affective repercussions. These repercussions are reflected in the themes of anger, resentment, and revenge. Let us now turn to the literature in order to incorporate insights gained from a deductive analysis.

Comparative Critique

Selected facts, concepts and theories from literature are used to develop an explanatory model which offers suggestions that will help explain the gap between what, in fact, occurred in these cases and what, in the nurse's words, they believe ought to have occurred.

In the examples evidence of a perception of imposed relevance and, consequently, inequality abounds. Inequality in status is particularly noticed in such statements as, (a) "there is no place for nursing decisions," and (b) "nursing recommendations are tossed off." Perceptions such as these seem to cause nurses to develop mind sets that, as Arsokar (1982) states, make nurses feel that they are "primarily means to the ends of others" (p. 30). This
perception leads to the robot-like, morally passive behavior Davis (1983) speaks of. It can be seen how these nurses did accept their role in a robot-like way (at least on the surface) as they acquiesced to behaviors grounded in Stage I and II patterns of reasoning that they, indeed, had trouble coping with. These troubles were due to cognitive dissonance and resulted in the need to rationalize or bolster themselves as they sought internal reprieve. However, these nurses could not fool themselves, their conflict of loyalty and the need to function in a professional way never receded.

Festinger (1962), the man who developed the theory of cognitive dissonance, states that when inconstancies stand out, people attempt to normalize them away; when they are unable to do this, they experience psychological discomfort which is called dissonance. In trying to reduce this dissonance, people try to avoid situations that cause it. This may well be why one nurse stated, "The nurses just for self protection, do not come to terms with anything until the problem is actually their's," and another said, "A lot of things get left." These activities, according to Festinger (1962), lead to dissonance reduction because attempts are made to make the issue relevant.

The theory of cognitive dissonance affords one explanation for the regression in patterns of reasoning due to milieu effects. Because, in essence, this theory states that two elements are in dissonance if, considering these two alone, the obverse of one element would follow from the other (Festinger, 1962) (i.e., following
physician orders promotes a standard of care which support patient autonomy). To Festinger (1962), dissonance arises from (a) logical inconsistency, as just cited; (b) disagreement over cultural mores; (c) one specific opinion taken over general opinions; and (d) past experience. While all four factors may contribute to nursing’s conflict, perhaps the first one is most evident in this study. Additionally, Festinger (1962) adds that the more valued the issue, the greater the dissonance created.

In the same sense as imposed relevancy, Festinger (1962) speaks of forced compliance. Forced compliance also rests on reward or punishment. He notes that once compliance is exhibited, there is a noncorrespondence between overt behavior and private opinion. The need is then to reduce the tensions aroused by increasing the number of consonant relations. This is certainly the techniques chosen by the nurses as they avoided risks and followed orders or dodged issues. The nursing administrators, in placating, also were trying to decrease dissonant relationships.

Caught in an attempt to increase consonant relations, nurses partook of what Janis (1982) calls defense avoidance strategies. In outlining a model of conflict resolution in decision making, Janis (1982) notes that it is common for people to use this negative strategy. It also helps decrease personal dissonance. Janis cites two techniques which fall under this strategy: rationalization and buffering. When people are unable to resolve conflicts, they
try to convince themselves that they could do no more, or that they did their best and need not do anything more. Evidence of this behavior is noted as: (a) the nurse rationalized that it was better the lady did not know of her nonmalignant breast, (b) the incident of the nurse checking on the caesarean birth, and (c) the nurse who saw the report on the inebriated physician torn up.

In other circumstances, these nurses may have done more but their perception of inequality, in these cases, held them back. Such behavior occurs when paternalistic leanings overshadow the rights of others to speak out. These leanings decrease feelings of dignity and self worth and lead to decreased motivation. Chaska (1983, p. 482) says that people then feel as if they are "things" or "objects" for instrumental use: human freedom is consequently limited. A sense of control is negated. Nurses were unable to promote the kind of patient care they believed in, they were unable to provide circumstances for their patients in which the patients themselves could take control.

Various elements in the milieu situation and features from within the nurse herself led to a perception of inequality and, consequently, to the belief that others make decrees and nurses follow. Preconventional levels of reasoning compounded by feelings of fear and inadequacy undermined higher level standards to the point that egocentric self preservative values took precedence over accountable behavior. Nurses who could function well at conventional
and postconventional levels found themselves angry, resentful, and revengeful, yet unable to change the present situation.

B. Bounded Relevance

Nurses who faced multiple loyalty conflicts with conventional level patterns of reasoning, felt that their right to function as a professional was limited or restricted by bounds inherent in the structure of the health care system. Conceptualizing such a complex and, indeed, perplexing category required an approach that presents the issues involved in such a way that elements essential to the controversy can be examined. Often it seemed that any action taken by the nurse would have an unfavorable outcome because it would lead to compromising one of the involved parties. Conflicts, at times, reached true dilemma proportions as nurses were pulled between various commitments. For example, some felt obliged to meet professional standards and to maintain a sense of trust and respect with the patient, yet policies promulgated by the institution and treatment decisions set by the physician forced a weakening of this commitment. Or, secondly, when looking at the interests of each group involved (e.g., the physicians, the institution, the patient and family), the nurse became unsure of whose values should have priority. This brought up conflicts pertaining to questions concerning quality of care backed by ambivalence which was created as loyalties were torn. In general, legal standards of care are upheld (i.e., the minimal safe standard) in each conflict of interest situation.
Nevertheless, the espoused standards of care that institutions present in their mission statements allude to care that surpasses minimal standards. Words such as exemplary care, or provision of high quality services, are commonly included. Similarly, terms with equatable meanings exist in the Standards of Care Document and Code for Nurses.

Not surprisingly, nurses who utilize Stage III or Stage IV patterns of reasoning, based on a member-of-society perspective which stresses the importance of either maintaining relationships or upholding social structures, struggle with divided loyalties. Conflict exists between what the nurses consider right or just action and what they consider responsible action given nursing's confined role. This ambiguous position led to themes which are grounded in issues that can be expressed as dilemmas. Stage III conflicts revolve around the one main theme of relationships versus role responsibility. Stage IV loyalty conflicts contained four main themes: nursing rights versus physician rights, nursing rights versus institutional rights, nursing responsibility and the right of the patient to die with dignity, and individual rights versus societal responsibility. The first theme to be discussed will deal with the nursing need to maintain relationships and to meet the expectations of others versus a need to perform responsibly within the nursing role.
Theme: Relationship versus Role Responsibility

Case #8

Descriptive analysis. In this case, the nurse believes in "the concept of the patient being an individual with rights of his own." Given this belief, she had difficulty coping with a situation in which a patient was not given adequate information concerning the risks involved prior to a surgical procedure. She was asked how she would further define her idea of patient rights.

R: The right [in this case] would relate to his right to participate in the decision and to make the final choice with regards to anything that relates to his health. But you come up with conflicts because, while nurses are supposed to have a responsibility to provide teaching, to provide information, so many of the situations in which we find ourselves we don't really have the control to do that properly. For example, the legal consent form says the patient must be informed by the physician, and no matter what kind of information I give them the legal system is set up that it really depends on what the physician tells them as that being the legal basis for choice.

I: So do you find that you are witnessing a consent form and patients are not informed?

R: Yes. Or not as informed as you would like to see them.

I: How do you know they aren't informed?

R: Because sometimes—not sometimes—often you listen to the doctors explain things to them and you can tell what the physician is giving them is a biased point of view. Maybe not offering all the alternatives, maybe not pointing out to the patient all the risks involved with the treatment they are about to accept, and then the patient signs the form because he feels helpless. He feels sick. He has to take the doctor's advice and have this treatment because, for some reason, he respects the physician too much to ask for, maybe, a second opinion. And then, after he has signed the consent and the physician has left, then, he still
has lots and lots of questions, and lots of doubts, and worries about whether he is doing the right thing, which he then verbalizes to you, the nurse.

I: And what do you, the nurse, do about that?

R: Well, sometimes you can go back to the physician and say, "I don't believe that the patient still really understands." Then, if he takes you seriously or not and will take the time to go back to the patient is a real, individual thing for each physician. Or you can encourage the patient to talk again with the physician, but usually by that point they have consented to the treatment and it is already booked, and usually it is rushed ahead and there's not that kind of time element to allow the patient to discuss it again thoroughly. Or else, because of the way he interacts with his physician, he doesn't feel comfortable questioning the physician's information to dig deeper for more information to get all his worries out of the way. Maybe he will feel silly or something like that.

I: Can you think of a patient?

R: Mmhmm. I can think of a patient who had an abdominal aneurism. . . . [He] had [a 5 cm] aneurism . . . and there was a time when vascular surgeons would say that if an aneurism was greater than 5 cm, then they would have to operate, and if it was lesser than [5 cm], they wouldn't have to. But these days it seems the criteria have changed so that it depends on the rate of growth. If the physician sees a person one year and it's 4 cm and the next year they see him and it's seven, then the rate of growth would indicate that it will rupture soon. So, based on the rate of growth, they will decide to operate. Now, this was a man who had many risk factors: he was a diabetic person; he had heart disease, had had previous MIs, had problems with heart failure; and he really wasn't an optimum candidate for this surgery. He had already had one previous stroke and the risk of stroke with aneurism surgery is very high. His rate of growth hadn't really been that high and so his 5 cm aneurism might have stayed for awhile without rupturing and his present quality of life was not that good because he was incapacitated by his heart disease.

I: Could he do anything on his own?

R: He could do things on his own. I was going to say that his quality of life was not that good, but it was still decent
enough, you know. He needed biannual admissions for cardiac problems, but otherwise at home he was independent. He lived with his wife and so on, and I remember that when we were discussing his surgery for the purposes of consent, the surgeon involved really didn't explain to him to my satisfaction anyway, and I'm not sure how important that is in the whole process that everyone else in the room be satisfied that you have got enough information, but I just thought at the time that the surgeon did not explain to this man the significance of his own personal risk. And, for sure, I felt he didn't at all explain to the man the risk of CVA and how high it was.

I: He didn't mention it at all?

R: Not at all, not as a factor, and the man went to the table and had a massive stroke and never did recover. And I think that the way the information was presented to him, he felt that he probably had no choice but to have the surgery.

I: So he had a 5 cm aneurism, do you know the rate of growth over the last 12 months?

R: His aneurism had initially been diagnosed about 10 years previous to that and at that time it was about a 3 cm aneurism, but in 10 years it had grown 2 cm.

I: His life expectancy was limited anyway, perhaps, with the conditions you mentioned.

R: Yes, most definitely. You know, a diabetic with heart problems has severe limits to life expectancy. And I think that he didn't—maybe he would have opted to have the surgery anyway. But I think that if someone had told him that the chances were about 75% that he would probably have another stroke, that risks are that high and might severely incapacitate him, if they had explained to him the really significant risk of putting somebody with that kind of heart disease on the table, then he might not have had the surgery. To me the expression of the danger just didn't seem to be explicit enough.

I: So, you would have preferred the surgeon had taken time to sit and let him calm down and then explained the facts and risks and even the percentage risk of losing his life? Is that what you would have preferred to happen?
R: Yes.

I: And was he offered any other alternative?

R: No, he wasn't. The whole discussion was predicated by the surgeon's statement that he felt that he should have this surgery; he had been consulted by the cardiologist and he felt he should have this surgery.

I: Can you just hypothesize on why, why the surgeon at that particular time was worried about the aneurism?

R: No, I can't.

I: But with all your experience, you can't see why the focus at point, particularly when he had been admitted for another reason?

R: No, I didn't really understand it at all at the time actually.

I: So how do you feel?

R: Well, sad, I guess. I don't feel responsible but I feel sad.

I: Why do you not feel responsible?

R: Because it is not up to me, it's not my decision, it's not my responsibility to give that information to him, and, while I may feel that it is my moral and ethical responsibility, it has no legal bearing on whether or not he should have had the surgery and the outcome was beyond my control.

I: So he was taking it on faith that the very best suggestions were coming forth, would you say that was correct?

R: Yes, patients have an ordinate and, I think, sometimes undeserved amount of trust in their physicians, and so, if this cardiologist, who had managed his life, I mean basically managed his life for about 10 years and had kept him alive despite his heart disease for 10 years, had recommended that a surgeon see him and then the surgeon comes and sees him and says that it is his opinion that he should have the surgery, I think that it would take the most strongwilled person I know to say to this man, "Well, just a minute, I want another opinion," or "I don't think
so, I just want to go on the way I am," because they also run the risk of incurring the anger of their physicians which realistically does have a bearing on how they will be managed in the future. It would be nice to say that it wouldn't but, in fact, I think questioning physicians often does.

I: It does what?

R: It has the effect of having the physician's attitude towards you as a patient change. You see quite often in conversations with physicians where patients have not been 100% compliant, say, to a regime of treatment that the physician will refuse to see them thereafter, or sees them but grudgingly, or sees them with very negative comments, and that will color the way they treat them, I think, from then on.

I: So have you seen that kind of thing happening where a physician is begrudgingly treating a patient in the unit?

R: Yes.

**Normative analysis.** Stage III patterns of reasoning directed this nurse in this particular case. She focused on how important it was for this patient to maintain his positive relationship with a physician who had virtually kept him alive for the past 10 years. Concomitantly, the nurse was aware of what can happen to patients who ask for second opinions, or who refuse certain modes of treatment. On the other hand, she recognized that on an ethical and moral level all was not well, although legally she acted within what she felt to be the correct standard. However, in stating that she would prefer a knowledgable patient, one who can make all final decisions, she certainly espouses Stage V reasoning. What is more, another typical trait of Stage V is an awareness of the moral-legal gaps in points of view plus the realization that these points of view are
difficult to integrate. The nurse felt helpless, morally and ethically speaking. She could not break what she perceived to be a limitation inherent in the health care system nor did she under the circumstances want to risk the patient-physician relationship or, in fact, her own relationship with the physician. As another nurse states,

We have to work with those physicians, we have to get along with them. And the other thing is, we can't take responsibility for jeopardizing that doctor-patient relationship.

This nurse went on to say that,

The physician is still the one who they are going to go to when they're sick, and you can't destroy that trust. So nursing has to do whatever it can within the constraints of whatever the situation might be. Nursing is bound by medicine—and that's what holds nursing back in all situations. We are forced to work within the bounds of medical constraints.

**Case #9**

Descriptive analysis. Once again, relationship needs come to the foreground as a public health nurse and a school-based team, finding little help within the system but guided by deep feelings of empathy for a child, continue to seek a relationship with the mother of an abused child. Nevertheless, a question arises: What priority should be given to a frustrating and long drawn out, time consuming, recalcitrant case?

This nurse sadly comments that in this particular case some members of the school-based team have given up. They have decided, she says, that the child will become a "street child". However,
some of the team continue to try to gain a positive relationship with the mother, who, as this nurse remarks,

R: Is in her own crisis with an alcoholic husband who beats her and who is in and out of jail. She cannot make a decision for her child—she is unable to make decisions for herself. And with the Ministry of Human Resources [MHR], if the parent refuses resources, everything is left. But her child has been sexually abused three times over one period of time, yet the MHR mandate for abuse and apprehension is so strict that you have to have so many criteria met before this child can be removed from her environment. Plus there are so few good foster homes. There is a bandaid approach to working with the family. But often they have had so many huge problems over the years that not much happens. We are all very frustrated with society as a whole re resources for this child.

I: How old is the girl?

R: About ten... For this child we have proof of the three occasions, but the child is getting physical care and she is not in danger of continued contact with the people. But there isn't a physical limit set on the child at home.

I: So she can wander?

R: Oh, yes. Plus she is a behavior problem. A street kid almost. There has been loss of control and no parental guidelines for years. But, you see, the Court knows that this child has been assaulted three times. They have facts about it. The other fact is she is physically cared for at home, though there are no limits put on her. The Court knows she is acting out—but they did not have any grounds to make MHR the child's parent. And only if MHR is the child's parent can they arrange to get the child sexual counselling. On three occasions the mom was asked to give permission for this. One time she agreed. Mother and child were sent to a psychiatrist in town. But he is a very busy man and they had one session together. The child refused to talk about sexual issues with him so he dismissed the case.

I: He expected her to talk in one session?

R: Yes. He dismissed the case because the little girl didn't want to talk about it. But when she was ready to talk about
it, he would see her again. But to me, any person, whether a child or an adult, needs to gain some trust with another person and know them over a period of time before they would ever talk about such personal emotional issues. Now, at school she feels safe. She likes the staff. It's the ideal place. But when she goes home and on weekends and holidays, she's back into a chaotic family life.

The nurse goes on to say that now, over a year later, they are still trying to reform a relationship with the mother. She says, "MHR is the prime worker and they have done the best they can—their hands are tied by their mandate and the law." The nurse says that they will continue with the mother in hopes that in time she will seek counselling for herself and her child. She says that over a year later some members of the school-based team, while feeling bound by the rules and regulations of the bureaucracy, are still trying to seek a positive resolution. They feel the child "deserves more."

When asked how the school-based team was going to handle the situation, she responded that the team was going to try to work around the situation. They were going to see if a psychiatrist would come to the school to counsel on a one-to-one or a group basis, or family services would maybe start up a group for sexually abused children. This approach, apparently, can be taken whether the mom agrees or not because it is sponsored by the school. The nurse was asked to comment on the latest idea.

R: I think it's okay. I think it's great. MHR are doing their best, but as long as their hands are tied . . . those of us on the team that are more emotional about this keep pushing.
I: Which side do you prefer?

R: I'm more for pushing and doing things for people even if it is a little under the table. I believe in people accepting responsibility for themselves and I wish we could push that with these clients—it's a slow process. But it's a fight with the societal bureaucracies—there are so many one has to coordinate with.

**Normative analysis.** The remaining group of interested team members seemed to base their stand on a third person perspective. For example, they seemed to consider norms of society as well as the feelings that they perceive the child might have. Relationship and caring for another was primary and is common to Stage III patterns of reasoning. Alternatively, when given a chance to comment on what she would prefer and, in fact, the team might instigate, this nurse adopted a Stage V pattern of reasoning. She was willing to go forward with a plan even if it "was a little under the table."

The rules within the system were unsatisfactory for her in this case. Again, the legal stance did not live up to the moral obligation felt by several members of the school-based team.

**Comparative Critique**

Conventional level Stage III patterns of reasoning focus on the meaningful nature of relationships. When conventional patterns of reasoning are examined from within the perspective of bounded relevance, nurses were faced with conflicts of loyalty that, at times, took on the force of a dilemma. Yet, choices had to be made. In examining how choices were made, we will review pertinent facts from selected cases while providing an abstract rendition of what theorists have to contribute.
In the case examples depicting Stage III thinking it is evident that the nurse felt conflict of loyalty when witnessing a patient giving consent while inadequately informed: the concept of patient rights was not upheld. But a belief in the value of a positive and trusting doctor-patient relationship backed by the assumption that she wasn't legally responsible for the patient's lack of knowledge, kept her silent. Her basic assumption is questionable because, as Fiesta (1983) remarks, the hospital and its nurses can be held liable if they knew there had not been adequate disclosure in cases of informed consent. In the second case, the "emotional" and very time-consuming need to find treatment for a little girl kept several members of the school-based team hoping that they could form a relationship with the child's mother so both mother and child would get counselling. (It may have been the same need for relationship that kept them from challenging the psychiatrist's hasty decision.)

Concern for another which is rooted in caring remains foremost: empathy with the other brings in an emotional relationship-promoting component. The conflict in each instance was recognized for what it was, yet the need to maintain the human connection Gilligan (1982) speaks of is paramount. Women, she says, believe that "fractures in human relationships must be mended" (p. 207). Correlatively, in the first case, the nurse did not want to sever the doctor-patient connection because she believed the connection was more important than the high risk of stroke and perhaps death that the inadequately informed patient faced. The nurse did feel a certain degree of
cognitive dissonance but to some degree it was reduced because she placed such a high value on maintaining the relationship. It came prior to her need to uphold Stage V values depicting fair and beneficial practices. With this in mind, according to Festinger (1962), the magnitude of the dissonance is reduced. Alternatively, it is possible that dissonance is lessened if the nurse either consciously or unconsciously decreased the importance placed on Stage V concepts thereby increasing the attractiveness of relationship. If this is true, then Janis's interpretation of defense avoidance techniques in conflict theory can at least partially explain the value placed on relationship. However, it is not known if this latter process was utilized; overtly, it appears that value is placed on relationship.

A formulation that places relationship prior to justness and fairness, Gilligan contends, may seem naive and cognitively immature; nevertheless, it is logical to assume that the restorative activity of care, communication and connection between patients and health care professionals is an additive factor in the healing process. In fact, both stress how helpful and often crucially important the human interpersonal component is: humane and thoughtful caring sustains and fosters hope in those who are unwell.

Interestingly, out of the milieu context each nurse was capable of Stage V patterns of reasoning: they were conversant with the effect of legal parameters and were cognizant of the moral implications of their actions. Nevertheless, in the social situation their concept
of value focused on the need for relationship and right action become equatable with relationship maintenance. In perceiving that nursing relevance was limited, their concept of moral worth as it relates to nursing's right to relationship with the patient diminished. Stage V perspectives were abdicated. Actions which could have promoted professional nursing standards as well as a sense of nurse-patient trust were set aside.

As we progress to the Stage IV reasoning, it can be noted that identified themes are grounded in a more cognitive rational footing versus the more affective perspective just discussed. In the following cases, discrepancies with either social or professional goals or value systems occur. In many instances, the influence of modern technology intrudes. Clashes of loyalty are often caused by the inability of some members of the health care team to truly see the human being—technological gadgetry or test results become powerfully overwhelming. The first theme will contend with the right of the nurse to meet defined obligations to the patient versus the right of the physician to specify the nature of the treatment.

**Theme: Nursing Rights versus Physician Rights**

**Case #10**

Descriptive analysis. The ensuing case provides insight into a psychiatric nurse's perception of the limitations set for nurses and her way of coping with them. "Patient autonomy should be encouraged," she remarks.
R: Patients should be able to maintain their individuality—their identity—and be treated by health care professionals with the respect that is due them as individuals and to be able to operate as individuals. . . . So that, I believe, involves responsibility on behalf of the health care professionals as well as responsibility on behalf of the patient.

She believes that nurses in psychiatry must help patients:

R: Maintain as much autonomy as possible, make decisions for themselves, and it is very hard to do that because a lot of times these patients look to us to make decisions for them. But [problems] hit home the most when I see psychiatrists behaving very paternalistically to patients and I find that quite disrespectful. I could see that sitting in a recent interview with a patient who was a [professional].

I: She was a female?

R: Yes, and her psychiatrist, a fairly young male, essentially sat there and told her that she should do these things because he is a psychiatrist and knows better, and that is pretty well exactly what he said.

I: So she had no options offered her?

R: Well, she could have chosen other options but he said, you know, if you want to get better, you know, you would listen to me because I have all this training and, therefore, I'm supposedly learned and if you want help dealing with your emotions that you can't handle, you will do A, B, C, and D. Very dogmatic.

I: So he actually gave her A, B, C, and D. In that case. And what did the patient do?

R: She cried in front of him and said she felt totally lost and helpless and couldn't relate to that [his suggestions].

I: Was she going to do A, B, C, and D?

R: I don't think so. I think she said she felt she couldn't do those things, she wasn't capable of it.

I: So what happened then?
R: He just sort of—I can recall the setting, too. She was sitting on the bed and there is a desk in the room over here and he came in and sat on the desk, so she's down there and he's sort of up here looking down.

I: And where were you?

R: And I was sitting in a chair over in the corner and I recall getting quite distressed at this. Not only—I felt he was quite cold in his approach and I wasn't too familiar with this particular psychiatrist. I had known him for as long as he worked here which was a couple of years. But I hadn't actually sat in and done interviews with him so, you know, I wasn't familiar with his style, so this came as a bit of a surprise to me. I didn't find it particularly warming to me but I thought, well, I'll just sit here and see what's happening and, you know, maybe he has something different going with this woman and I don't know. I felt it was quite distressing because this woman became a lot more distressed as he went along and it didn't seem to me that he was getting anywhere. So finally I pointed this out and said, "this doesn't seem to be helping us," and I don't think there was any huge resolution from that interview. Because I felt dissatisfied with it, I thought I better check it out afterwards. So, then, I sat down and talked with the psychiatrist and tried to find out, you know, the background. Maybe she [the patient] had been very difficult to deal with and this was sort of the last route he had to take. I did feel good in that I checked it out and found out that in my judgment he was just lousy, that's all, and wasn't being helpful at all. And I, actually, was quite open. I told him that's what I thought. A lot of the other staff felt the same way. And we [the nurses] tried to alter our plan with this woman.

I: How old was she?

R: She was in her young twenties.

I: And you took the step of altering the plan with the patient without his A, B, C, and D?

R: Yes. It didn't particularly involve doing whatever it was he said—I can't recall now, I wish I could, it would help. It seems to me fairly typical though, when you are working in psychiatry on a team basis, we don't all agree all the time. And also on the ward I work on, the nurses do most of the work in terms of the amount of time which is spent in interacting with patients.
I: So do you set up a plan that doesn't need a physician order then, and you actually do therapy and you don't need physician involvement?

R: Yes, we tell him what we are doing. And, basically, probably they don't really care what you do as long as they are not violently objected to it. You have to realize that there are some psychiatrists that are a lot more involved with the work than others are.

I: So this is a psychiatrist who didn't particularly have to be involved, he didn't mind?

R: No.

I: So you were free to make your own plan. Well, how did it work when you made a plan with her?

R: Well, I would say she was discharged improved. She was a very difficult person to work with, you know, that sounds judgmental but everybody found her very difficult. She herself acknowledged a great deal of difficulty in feeling that she was making improvement in the things that were bothering her. . . . She had tried to kill herself . . . but wasn't injured that badly. . . . She herself felt she couldn't explain why or rationalize it or talk about it to any huge depth. It was just that she did it and it was over with and she won't do it again.

I: Do you feel that the nurses made any real progress with her?

R: I'd like to think that we made progress. I think we related with her much better in that I felt that there was more of a connection—that she felt understood with us and that she felt by being understood, better able to open up and try to identify some of the things that were really bothering her.

I: Did she have a plan when she went home then?

R: Yes.

I: Was she able to plan something she could contribute to?

R: Yes.

I: And that was due to her nurse making that plan with her?

R: Yes, we worked on a plan. As a matter of fact, we got a card from her not too long ago.
Normative analysis. This nurse in characteristic Stage IV reasoning was quite clear on where she stood within the system. She was also aware of her nursing obligations. After having to undergo an unpleasant interview situation, she questioned the physician about his approach and then, well within her rights as a nurse, she helped the patient devise a care plan which would be effective. The physician had the right to veto the nursing plan but chose not to. Still, in this kind of situation, it is worth noting, parenthetically, how often a responsible nursing plan is vetoed and, in such cases, what little right the nurse has to proceed as her judgment dictates. Further, even though the plan of care proceeded, it is likely that the patient had to overcome feelings of powerlessness enhanced by the initial therapy session. Loyalty, once the physician's rationale was assessed, went to the patient; nevertheless, in the initial interview, the nurse was unclear about where her primary loyalty should be directed.

Similarly, in the succeeding example, nurses' rights are infringed upon and, in this case, to the point of at least vicarious liability and, at the most, direct liability.

Case #11

Descriptive analysis. The setting again is in psychiatry. This nurse believes that the philosophy of her unit, succinctly put, states:

The road to health is paved by people taking responsibility for themselves and part of that responsibility involves recognizing when they should be in hospital. In other words, acknowledging that they have a problem that they want to do something about.
That philosophy is fine when all legal proceedings concerning hospital admission are followed. But this nurse has been caught with a difficult issue: she is expected to provide nursing care for patients who have neither signed a consent nor been committed. She says,

R: I came to work after days off and there is a patient who has been there for 24 hours that has neither a signed consent nor been committed—and I just make it very clear to the medical people involved and any supervisory people around that I am not doing anything with the person because they are not here voluntarily and they are not committed.

I: How can they be there without any kind of consent then?

R: It happens a lot in psychiatry, I'm sure. . . . You see this a lot with ambivalent personalities.

I: You mean they won't sign, yet they'll stay?

R: Yes. They won't sign, yet they'll stay. Well, I tell them, "Look, if you are not willing to sign, well leave." And they don't leave.

I: Will they sign for you, then?

R: No, not necessarily, no. . . . And it is not up to nurses to write committal papers, they can only be written by medical personnel; however, we are often left holding the bag. . . . Well, two weekends ago, I was working nights. I came on and there was an elderly woman who had been admitted, I believe, on the advice of her GP. She had been at home, not eating, refusing to eat as a matter of fact, had been in the emergency department once to have her electrolytes restabilized and to be rehydrated and went home, immediately deteriorated and came back in by ambulance and was admitted directly to the psychiatric ward. She refused to eat or drink anything, refused to accept any form of self care, and, in fact, she required total care. She was incontinent in bed and had to have an IV started. I realized—I think I was there the second night she was there. I started work and she was neither committed nor had signed a consent. As far as my understanding of the legal procedure goes, the doctors, the hospital, all sorts of people, could have been charged with assault for the procedures they had instituted on that woman without their
being consent or committal. I was quite angry about that because I don't like being placed in a position of jeopardy and I also think it violates her rights.

I: So, what did you do then?

R: So, I told the nursing supervisor, I told all the other staff I worked with, and informed the doctor on call, the psychiatrist who was covering the ward, that, you know, something needed to be done about this. I guess what angered me was that it took somebody coming to work on a Friday night whereas the woman had been there two days and it should have come to somebody's attention, particularly her doctor's, the psychiatrist on the ward.

I: Is this an example, then, of consent being more or less ignored?

R: Well, it becomes a matter of setting priorities and I think, unfortunately, a few basic things get missed in the priorities, since obviously somebody has made a judgment that this woman is not competent and needs our help right away or she is going to die. Now, if she was left in her apartment, she would have died. And, therefore, she had to come in.

I: Did she actually get committed?

R: Yes, she got committed that day, the day that I reported it.

I: Is this the thing you mean where nurses get caught holding the bag? It seems that nurses are doing a fair amount of actual assessment that makes a real difference.

R: Oh, I think so. I can recall again on the crisis ward where they would get people in more acute phases and get a lot more acting-out behavior which required immediate intervention such as IM injections of major tranquilizers. We frequently would be asked to inject people who had not signed consent or been committed. Fortunately, I worked with a very good team of nurses who made their stand pretty clear on that. But we had to do it quite collectively.

I: What was your stand?

R: The stand was that we say to the psychiatrists that, you know, I'm not going to give that injection to that person until something is done as far as them either giving an
informed consent or you getting them committed. Because it was a violation of their rights. And I guess it wasn't so much an ethical dilemma because I could certainly appreciate that they probably needed that medication and, in fact, it's almost cruel to deny it to them because they are in a great deal of distress if they are hitting out or in such a degree of distress that they don't know really or don't appreciate the nature of their actions. So they really need it, but I mean the laws are there to protect them as well. I think that what was probably annoying about that is the psychiatrist who was director of that unit seemed to be very flippant and sort of slack in employing those principles. He was sort of making sweeping generalizations like, "Well, I'll cover you all in a court of law if it should come to that," and I said, "Well, thank you, but I prefer to cover myself." You know, I just—it really was a case where we had to stand up.

Normative analysis. This nurse stood up for her rights as they are stipulated within the system and sanctioned by the law. This pattern of reasoning exemplifies Stage IV thought. She refused to continue providing service until patients and staff alike were protected for both ethical and legal reasons. Where at all possible, she prefers that patients decide on their care. When this is not possible, commitment is. The physician has the right to commit a patient; it is her belief that he also has the obligation to do so if a consent is not signed. Patient rights are then upheld and nurses and physicians alike have met defined obligations.

Our final case under the theme of nursing rights versus physician rights has to do with nursing's right to information which can assist in the understanding of a disruptive patient.

Case #12

Descriptive analysis. A lack of pertinent information in this case added fuel to what was already an unpleasant situation. The incident takes place in a unit consisting of mainly elderly people.
R: One physician admitted a young 17 year old girl with pelvic inflammatory disease [PID]. And to say that she was a major behavior problem was putting it mildly. She was the worst one I have ever had to encounter. She was verbally abusive to the nurses. They couldn't do anything with her. And she kept using the famous four letter word. She kept her curtains drawn. She was in a four bed room with three elderly ladies—one was dying. The ward was full—we had no place to put her. And she was a street kid, and street-wise. I don't know how long she had been on the street. . . . We were not managing her well, and we were not coping well with her. These kids are hard to love—they are very hard to love. And it is very difficult as a head nurse to support your nurses when they are being verbally abused. They get fed up and they didn't get the emotional support they needed. I thought that there should be some place else for a 17 year old to be put. She'd come to the nursing station and have major tantrums. I didn't think the woman who was dying should end her last couple of days hearing that. So we phoned the physician and mentioned we were having problems managing this child and would like to consult. . . . So we had a meeting. . . . One of the things that distressed me, and I regret now not taking it up further [in the meeting], was the fact that from a social work aide we had learned that this girl had been sexually assaulted by her father or her stepfather as a child and she—the nurses' attitudes changed toward the girl. Oh, isn't that terrible—that's why she's like this. And, oh, what a terrible life, you know. And their approach to her changed. And during the conference, I brought up to the physician how—the problem she was causing on the ward—that she was very disruptive. And that we were finding it hard to keep her on the ward. Yet the girl was ill with PID. And I suggested that the Children's Adolescent Unit be tried because the nurses there know how to deal with adolescents. Although not all adolescents are like her. . . . The doctor hadn't heard of the adolescent unit.

R: The doctor wasn't interested but I encouraged her to look into the adolescent unit. The rest of the conference involved the doctor describing the process of PID and noted that there is something we can't say. This is why I wish I'd taken the doctor up, but it wasn't right for that discussion—or that kind of confrontation. And the fact that some awful thing had happened in this girl's life that the doctor really couldn't discuss with us. And I was upset at that statement, really upset. And in some ways I wish I'd taken up on that statement right there and then and said,
"you expect us to give her good care, yet a professional social work aide is given that information and just happened to let it drop [to the nurses]. And we are denied that, how can we care for this person?" I would certainly, if we had a patient like that in again with that kind of behavior, I would call the doctor on it. She did get into the adolescent unit.

I: But you noted that when the nurses actually found out that there might be some cause, or some explanatory reason for such behavior, that they could then approach her differently, or did they feel differently?

R: Oh, yes. Yes, and when they were called names they didn't feel it was so personal—they realized that there was a reason for it.

I: So sharing—

R: Sharing that information is very important. And if it is denied the nursing staff—I feel that as professional nurses, that we should be given that information to better understand and care for a person. You know our profession holds sacred and dear to us confidential information. And I wondered where this doctor thought half of us had been.

I: This conference did have its effect?

R: It did have its effect, yes.

I: Is that what you preferred, what happened?

R: Yes, I did, for the sakes of the other patients too.

I: And for the girl?

R: Yes.

It is interesting to note that sometime later another physician, one who chose to work with the nurses, admitted a girl with a similar problem to the unit. The nurse comments that they could care about her, could understand her behavior better, and could talk to her.

R: She was managed well. Her physician was frustrated with the system because he was trying to get help for her. He thought she had potential.
I: When she got out?

R: He said she was fortunate, they'd found a good foster home and the foster parents were willing to pay themselves to get her counseling if she would go. The physician had conned a psychologist who specializes in sexual assault to take her on at a cut price. And we were lucky to have the support of that physician.

Normative analysis. This nurse's thought is representative of Stage IV pattern of reasoning. She works within the system: she only asks for more cooperation and consideration so that patients can receive maximum understanding. She gives two excellent examples of the difference that can occur when health professionals work in unison to assist their patients.

In the first case, she perceived a lack of professional relevance, and thereby felt limited in what she could say to the physician; in the second instance, she was a colleague. She now feels a little more prepared to work within the system for change and will challenge the unsharing physician if necessary in the future.

Just as nurses feel bound by physician rights when they perceive a conflict of interest or loyalty situation, they also can feel bound by the rights of the institution. In all cases, the desire is not to undermine the institution, but to bring forward concerns pertaining to policy issues. Conflicts often revolve around differing views on one question: what are the characteristics of sound institutional policies which reflect fair and just dealings on a political, economic and interdisciplinary level, such that the consumer's rights and the nurses' responsibilities are protected and promoted? Let us examine cases in which expression of this theme is evident.
Theme: Nursing Rights versus Institutional Rights

Case #13

Descriptive analysis. The dilemma for this nurse is prompted by concerns relating to the economic pressures the health care system is undergoing at present and the toll restraint is taking on the quality of patient care. She compares the cost of maintaining life when a patient has little or no hope of survival with the loss incurred at the other end of the system (i.e., for patients who will survive but require adequate nursing time and teaching to upgrade their level of functioning).

This nurse speaks of patients who are in multisystem failure and in the terminal phase of a chronic disease being maintained at great cost to a system that is "severely strained financially." Yet, she says:

R: We've just come through a year and a half of being cut in the hospital budget—so they have cut nurses. Cut to the point that you are looking after—looking after two ventilated patients with various intravenous drips. Plus, you relieve other nurses when they go on breaks and take on more patients. An impossible task—impossible quality. And we are lied to, told all kinds of gross things. It is just amazing what money will make human beings do! But they will. We actually felt and saw the calibre of actual critical care just take skids and all the people just making excuses for this.

I: People meaning?

R: Nursing, nursing administrators telling us that we were disorganized, we were this, we were that. In the end they had to face the facts. In the end we had to resolve the problem. We resolved it by documenting and documenting and documenting. And it is gross. . . . Eventually, nursing administration did do something about it by closing
beds. But it took them a year. It took them a year to do that and it took them blaming us, and not being supportive of us. It was not until we started writing things down and the articles in the paper started getting a bit dicey that they started taking steps. So I don't give them any credit for moral fortitude whatever. They had to be threatened before they would see that. A simple solution. I don't blame the provincial government. We can't afford any more, we have to make changes from now on. Now I think that nursing is usually synonymous with female and I think that means we get the short end of the stick . . . I don't think we're getting a fair share of the money. I think the staffing has to be maintained but the need to cut costs has to be considered, but not at our expense.

I: Not at nursing's expense. All that documentation, I suppose, brought in the issue of legal liability. . . . And then the nursing administrators supported you.

R: Now they will say otherwise. They will say they've been doing this but the facts are there. And when they got their courage up, there was hell to pay for that for the nursing administration.

I: What kind of—I don't know what that means?

R: Well, what that means, because in our ICU open heart surgery, which is sanctioned by the provincial government, had to be cut. The government is saying you can double your open hearts. In doubling the open hearts—the losers—oh, they are doing people who have a lot less chance of making it than they used to. That means our ICU beds are filled with a lot of very ill, open heart patients who should questionably have had the surgery in the first place. Ah, but then we have closed beds and they can't do the open heart surgery, they don't get money, and the surgeons are up there screaming because they are not doing the correct number of surgeries a day.

I: Screaming at nursing?

R: Screaming at anyone who will listen. But it all comes back to because nursing closed those beds. And the fact is that there is no comprehension that you need nurses to look after these people.

I: But nursing under a fair amount of duress supported the staff nurses and quality of care?
R: Yes, well, yes, I think out of fear.

I: Out of fear?

R: Things haven't changed at all, have they?

I: It's unfortunate because nursing could work with nursing.

R: Support.

I: If we all work together, we are stronger.

R: That's right.

She goes on to say that the pressure created by inadequate staffing and sicker patients creates "a change over of staff about every two years—just at the point when critical care nurses get their most useful, they leave."

I: The nurses leave?

R: Yes. Well, they burn out for a lot of reasons. But for one thing, there is no interest in keeping—in worrying about how you can keep nurses from burning out. You have to keep that kind of experienced person there. Everyone else is going to have to learn it again.

I: There is no support to keep you there after two years when you finally have mature people?

R: No, and yet I'm not keen on leaving. You see because what I gained—I gained so painfully not just through one experience but through an accumulation of experiences. And having reached that level of maturity and knowledge where you think you can really be effective plus teach others as well. You can be an example and encourage others to have humane responses.

She says how important it is that nurses be considered, for shifts to be split, for leave of absences without pay to be available, so nurses can re-energize.

R: Except it is not very important, you see. The system is more important than the calibre of the people there. Who
is concerned that there is a turnover every two years? . . . Nursing administrators should stand on their professionalism and then say back what they are going to do. Why do they let us struggle and try and document and go through moral hell? I mean, why don't they anticipate problems before they happen? Everyone else can—they could have too.

I: So it seems from what you are saying that it was the grass roots nurses who instigated the change?

R: That's right. It's irritating that it has to be this way. That's not what I expect from administrators—if that is what you are going to be, then there has to be some kind of liaison where administrators represent me. I honestly don't feel that there is anyone representing the grass roots nurse anywhere.

**Normative analysis.** Thinking congruent with Stage IV patterns of reasoning is voiced through this dialogue. This nurse is aware of what her professional duties and responsibilities are. She also cares for critically ill, extremely dependent patients—she is their advocate. An unsupported advocate. Although trying to perform at a quality level, wanting to fulfill duties to which she believes nurses have a right to fulfill—duties which are encompassed in the roles and rules society has set for nursing—she is continually frustrated by bureaucratic policy. Such policy places critical care nurses in situations of "moral hell." It is little wonder these highly experienced nurses leave in two years. They are unable to live up to their mandate to the public they are there to serve. The institution has the right to make economic decisions: it is the form the decision takes that causes conflict of loyalty and nursing burnout. Unable to fulfill duties agreed to as a nurse and feeling
vulnerable and open to liability, the nurse phoned the RNABC for guidance and then began documenting at-risk situations—these nurses followed a legitimate route to force the issue.

The next case is somewhat similar as it refers to how funding allocation affects nursing.

Case #14

Descriptive analysis. Time spent with patients remains a critical issue, this nurse speaks of being "barely able to do basic [nursing] functions much less take time to be creative with patients."

R: I personally think that this is really important, that you are not just there as an observer of the patient or a recorder of data and that patient welfare is your responsibility more so than anyone else. I have accepted as a day-to-day fact that what you do at the bedside is important. We are the ones that get the pain medication and all that coordinated, make sure they get adequate analgesia, that they are comfortable, that things that are making them uncomfortable are dealt with, and that dangerous turns in their condition are treated. It is not that the medical staff doesn't care, but their bent is completely different and they don't spend the time—they don't watch what these people go through. The patient lying there critically ill in bed, even if they don't remember the experience in most cases, if they survive, they are completely dependent on nursing care for everything and that includes the type of medical care they receive as well.

I: If you want your patient to be comfortable, you have to say something and challenge the fact that there is not enough ordered or the wrong combination of orders?

R: Exactly, and I accept that as the norm so I don't consider that irresponsible on the physician's part, I consider that nursing initiative.

I: Do the physicians consider that a norm?

R: Yes.

I: So they expect the nurses to evaluate their orders in a sense and update what needs it?
R: I think they are a little too dependent on it. But because a lot of staff are new, they never had the opportunity to learn to prioritize work—they are just thrown in.

I: Can the quality of medical care be reflected by the quality of nursing care?

R: Yes, exactly.

This nurse says she prefers to work with the nursing administrators and other members of the health care team by making headway through consistent persistence, diplomacy, documentation, and being firm but reasonable. And they have made some headway, she says.

R: You don't get everything you want, but with a unified, intelligent voice you can make gains. You document incidents not to bring the medical people up on the carpet but to let them know you are aware. You have to be quite firm and set your limits with these people. I think they don't understand patients as nurses do. They are not watching the patient suffer. I think if they were, they would be more aware of the need for care—the human aspect of the issue. In self defense, they ignore it.

I: Why?

R: Because of the absolute awesome responsibility they have towards the patient and the result, if there are complications to the treatment.

Normative analysis. Supporting the patient and protecting the dependent, critically ill patient remain priority objectives for this nurse. With Stage IV patterns of reasoning, she places her view within the system's perspective. It is obvious that to her, medicine has more say in who gets what throughout the bureaucratic structure; moreover, she recognizes the institution's right to make funding decisions. Nevertheless, undaunted, she describes what nurses can do. She perceives that nursing can work within the system as it is
today by setting firm standards and being consistently persistent and with a certain diplomacy, documenting instances that run counter to patient safety or quality care. In their interviews, both of these nurses spoke about the need to promote the patient's rights and to spend time with the patients working with them so they can attain an optimal level of functioning. They cited what happens when nursing funds are cut.

Underlying the second case, and directly stated in the first, is the need to look at where money is being spent and how. The next theme to be presented looks at one aspect of this issue while concentrating on the patient's right to a dignified death.

Theme: Nursing Responsibility and the Right of the Patient to Die with Dignity

This area is one that is full of controversy in health care today. To reiterate, this study is not designed to advocate an approach to care, nor is it designed to lay blame on any one group or profession. We all contribute to our society. We are all responsible for what happens. Further, the topic of death is still shrouded with mystique and to some extent fear in society today; therefore, it is not surprising that many of the most heart rendering and complex conflicts in the health care system today, pertain to values and beliefs associated with the treatment or nontreatment of those who are terminally ill. The following case examples offer nursing perspectives on the issue. These perspectives are steeped
in perceptions of helplessness due to the nurse's feeling of bounded relevance. Although all involved, physician, nurse and family alike, are doing their utmost as it is defined from within their own perceptions, to care for those who are dying, nurses feel their responsibilities to the patient are often compromised to the detriment of patient and nurse.

In general, each case presents an individual who is dying, who has little hope of survival beyond a brief time span, if at all. Full treatment is undertaken. The nurses, all maintaining Stage IV patterns of reasoning in the actual conflict situation, are placed in extreme conflict of loyalty positions. They honor the autonomy of the individual who is undergoing treatment and who has suffered almost complete loss of autonomy; conversely, they honor the system which, in these cases, supports a rule which states: treat at all cost, treat as long as anything is treatable.

Case #15

**Descriptive analysis.** The patient is a man in his sixties. He is cared for by a nurse who believes patient autonomy can be upheld, even in the critical care unit by,

R: Finding a way to communicate with the patient, by involving the family in the care—finding out what the individual is like—that helps a great deal, it gives the patient some right to decision making.

I: Can patients actually make a decision then?

R: Some can . . . the ideal situation is where someone who had a terminal illness could decide—they would be informed of all the options and treatments available to them.
I: Does that happen often?

R: I find that [hospital] is very, very aggressive.

I: What does very aggressive mean?

R: Very aggressive means they will maintain extraordinary means to support life in patients where the prognosis is poor with great physical suffering to the patient.

I: The prognosis poor and at great physical suffering—has the patient been asked?

R: No.

I: Has the family been asked generally?

R: Most of the time. But sometimes that is disregarded based on the aggressive philosophy of the medical unit. . . . They will maintain life as long as there is an infection present, as long as there is some sign of sepsis because that is a "treatable" cause. In real life it is not, but philosophically it is. So we give them another antibiotic and extend their life until they have had their course of antibiotics for 3 or 4 days depending on the drug.

I: So that might be a time for decision making, when the course of antibiotics has ended?

R: Decisions are made but they are often prolonged. Not long ago we had a cancer patient in our ICU. He had leukemia, he was intubated and ventilated and he lived, horribly, for six weeks.

I: What does horribly mean?

R: Horribly means that he was septic—he was a human petrie dish—he was immunosuppressed, he was bleeding actively, because of his sepsis he was third spaced. The total parenteral nutrition [TPN], the dialysis and everything to keep him going caused fluctuations in blood sugar and electrolyte imbalances, sores, infections, scleral edema, he couldn't close his eyes.

I: This was for six weeks and then what happened to him?

R: He died.
I: To your knowledge, was he ever asked, at any time, what he would like?

R: To my knowledge I don't think it was ever discussed with him but it was discussed with his family and they wanted aggressive treatment.

I: Even when they saw what the aggressive treatment was doing?

R: There was some problem with the family. They didn't get along. They had different opinions. If you have ever seen someone like that!

I: I haven't seen anybody quite like that.

R: I have seen a lot of people like that.

I: I think I would have found it difficult.

R: He looked hideous, his consciousness would fluctuate and he withdrew. Patients just withdraw, they don't want to be there and I think that was the case with him. . . . Initially, it started out, well we will see, we'll try a few things, but it just kept on going and didn't stop.

I: So, initially, the intent is a good one, will buy him some time, yet there is no criteria to stop till the end. What would you consider a more ideal approach?

R: Actually, I think they should have discontinued treatment and done this earlier. He wasn't even kept comfortable because of his low BP and septic shock and the need for continual neurological assessments.

I: So would one priority be comfort?

R: In this situation.

I: Why would you prefer invasive treatment to stop and comfort measures to start?

R: Because I thought causing all that pain and discomfort was not going to gain him anything. To me it was unnecessary after a certain point.

I: Do you find that that happens often, that initially in an ICU the intent is really admirable, but somewhere along the line it slips and starts deteriorating into something that is a mess basically? Is that common or not?
R: That is a common occurrence.

I: How are you affected?

R: You have to endure certain things and you make it through, it is not pleasant.

When asked what conditions deter this from happening, the nurse noted that at times patients will put what they prefer in writing, or will tell a family member. However, she also noted that sometimes patients feel it is the end when it isn't. In these instances, she stresses, patients need to be told that they can recover for a period of time.

When asked what she would prefer, she again stated that patients must be informed and then be permitted to make their choices. Plus, she wanted a priority put on comfort and invasive treatment measures stopped at an appropriate time.

**Normative analysis.** This nurse, in accepting the system she works under, "endures" some of the negative features of it. Caring for a dying patient who is suffering greatly while aggressive treatment measures are employed is difficult. It must influence the burn out and high turnover of nurses in critical care units. As a previous nurse noted, "We are there to see the patient suffer." In typical Stage IV reasoning, this nurse would prefer that a more equitable state of affairs be set up within the system. She recommends (a) that patients be informed and given a choice of treatment, and (b) that assessment points be instigated so aggressive treatment can cease when it is clear to all involved there is no hope of recovery.
Nevertheless, in stating this, the interests of each constitutive group are to be considered as social and moral agreement is sought.

**Case #16**

**Descriptive analysis.** Another critical care nurse stresses the need for the health care team to see patients as human beings with a right to autonomy and for the patient to understand the economic strains of the system. She says nurses would like to make recommendations but nursing input is limited. She is referring to a case involving a sixty year old alcoholic male,

R: Who had drank himself into total body rot. His wife had gone and his business had gone—both for the past ten years. And every system he had was in a state of degeneration. Now, as far as I'm concerned, what we did for that man was purely experimental which is immoral. He obviously had nothing to live for—he had to work very hard to do that much destruction to himself.

I: How do you see what nursing and medicine did to him was experimental?

R: Just that they bothered to keep him alive.

I: Just bothered at all, just to see if it worked, you're saying?

R: Yes, to see what we could do. I mean, they did not perceive it this way. Medicine didn't think—let us practice here. But that's because their eyes—they had blinkers on. There are statistics about system breakdown. When you get into your fourth nonfunctioning system the fatality rate is 90%. Well, he didn't have any systems that were working. He didn't have anybody to care about him. He didn't have any future to get into. I don't know why it is, I look at it and it is so obvious. Yet I'm working with all these wonderfully dedicated people who don't see it that way. And for my own peace of mind—I don't stress myself in those circumstances. I mean I'm not going to make those moral decisions. But in order to keep my sanity and my perspective, I call this an experiment. A little bit of ignorance, a little bit of not wanting to see—or whatever—and I hope
that what I am doing will have something going for it in
the name of an experiment.

I: You want to see the good in it?

R: Well, to make some excuse for what I'm doing thinking that
I can't really find a good reason. Otherwise, why should
I do what anybody's saying? So, I guess, maybe that
experiment is my view of justifying why I carry on. I
don't want to see this. I don't want to see this patient
the way they're seeing him. You know, I like the view I've
got. The view I've got makes a lot more sense to me than
their view. So by putting in justification—one I can
handle—I can keep my own point of view and still function
in this environment without too much of a loss to myself.
The loss to myself would be what would bother me—I don't
want to start thinking in terms of—the way these people
are thinking that this is a case of total body breakdown,
let's see—

I: But you do know that it is hopeless?

R: Yes.

I: How long, incidentally, did that man go for?

R: Probably two to three weeks.

I: In the ICU?

R: Yes.

I: And then what happened?

R: He died.

I: Then he died. So two or three weeks of staff, drugs,
equipment, time, etc.—

R: Doing the whole thing. I mean, hitting everything you
could possibly do. You know, dialysis, TPN, everything
absolutely possible to meet all these needs. We weren't
neurologically getting anything but, "that could come back
couldn't it after everything else goes?"

I: Is this mode of thinking quite common in ICUs?

R: I think it's not thought about, I don't think medicine thinks
about it. I'm not quite sure how they use their criteria.
They are just wound up to save lives right. And they just—somehow they don't look at the surroundings, they don't make judgments because they don't have to. They just go in and put their heart and soul into doing this job. I don't think they see it on this—we're not going to save this man's life anyway—but let's see what we can learn from it. I don't think that's their conscious thought process at all. And I use that one when I have to, when I really feel that I shouldn't be doing this. I guess it's because I am exquisitely aware of the price that's paid on the other end of the system—like nurses on the medical wards who are not given an opportunity to deliver health care or nursing care that they would be able to do had they been given some honest support. Here we have money draining out.

She sees reason for nurses to be in conflict and to be insensitive.

R: Why be sensitive and burn yourself out in three months trying to be a human being when the system is not set up for you to be that way?

I: What ought to happen?

R: I've come through an era where people were selected codes—and it was obvious that it was the nurses who were deciding that someone who was 75 years old and senile—somehow the thought of calling a code on him never occurred to us. This decision didn't feel uncomfortable at the time. Now it [calling codes] is just done as a matter of form. I find it appalling. I just can't understand it. . . . There is a crying need for somebody to start setting up an ethics committee because we simply—the Health Care System cannot handle everyone going through an ICU. I mean, they scream about the costs of these units—we have staffing problems because they are not prepared to staff them. There are all kinds of philosophical questions I am prepared to tackle with this but will stand in judgment of people who won't tackle them. To think that we should save a life at all cost is wrong. It is very ideal and would be nice—we cannot do it because we do not have the funds to do it. And when we think we do have the funds, we are robbing the other end of the scale. It can't be done. So some kind of compromise must be made and that means some have to be told yes and some told no. . . . I just think people make choices and why should I interfere with your choice? I mean, if your choice is to drink yourself into oblivion—then, so you know the consequences, so why should I jump in to save you?
I: So you are saying in a sense that, why should we as a society, I gather you might be meaning, support someone in an ongoing state of alcoholism well into old age when their systems are going and they are going to have to be chronically maintained in critical care units?

R: Yes. Yes, the whole time... We don't have an end anymore, that's not entirely true but, is that any better than having a dignified end three years earlier?

I: So this loyalty problem, if I'm looking at it correctly, this time you would be supporting a sensible system versus maintenance of life at all cost?

R: Exactly.

Normative analysis. It is evident that the nurse looked at patient choice from a two-dimensional viewpoint. First, she believes patients should be considered and asked what treatment they prefer—especially in the terminal phase of chronic illness. Secondly, she thinks that society must set criteria for treatment which places some responsibility on the consumer on a lifestyle basis. In wanting the system to function optimally, she fears the costs incurred when those who are in the end stage of a chronic illness are given maximal treatment. This lessens the care given to those who will survive and may need excellent nursing care (e.g., to provide lifestyle counselling to help the patient accept responsibility for self). Morally, she is aghast at the way choices for treatment are made. Yet she selects, as is congruent with Stage IV patterns of reasoning, to work within the system but suggests that a review committee such as an ethics committee could provide guidance on treatment issues. At present, perceiving nursing's lack of relevance and, therefore,
inability to provide responsible nursing input, she rationalizes, calling the worse cases experiments done for the sake of gaining knowledge.

Case #17

Descriptive analysis. Correlatively, similar problems occur on the children's units. This nurse believes it is important to look at the family as a unit, to inform them and then let them make decisions on treatment options.

R: Most children are not autonomous, and especially the premature infant, he is not autonomous at all; in fact, there is nothing autonomous about him, he can't even breathe on his own most times, his little heart beat is about all he's got going for him. Though when you have chronically ill children, I find they start to make decisions younger, they seem mature, become more sophisticated, and they will make rational decisions, like I don't want anymore, I've had enough.

But often a child is left, no decision is made and the legal side of the issue enters because:

R: If you stop treatment on this child and he dies, are you going to be legally responsible, you are ethically responsible? We have had children in our ICU where there is no hope that the child is going to live, grow, or do anything, is semi-comatose, probably uncomfortable, certainly unhappy if he has enough intelligence to feel those sorts of emotions, and the parents say we want you to treat and they show up every month or two and say, "We want you to treat," and you feel this child—we are not doing anything for this child except prolonging the agony. We did this with one child, since he was a newborn, for a little over a year. He was a severely limited hydrocephalic child and the parents knew the prognosis. And there was a feeling that if we didn't maintain his life to the best of our ability, that there was a danger of a lawsuit. . . . This case was very difficult to look after. You had to really—the head nurse found it very frustrating because the child would take the lower priority of everyone, he
would be ignored in rounds, because basically there wasn't a change and you had to force the physician to come and look at him. Nurses didn't like looking after the child, they didn't feel they could do anything useful or worthwhile. He was semi-comatose or comatose and on a ventilator. If we stopped aggressive treatment, he would die—removal of therapy would kill him.

I: What do you think is a preferable approach?

R: I guess that people would be willing to sit and discuss the case and make decisions at points along the illness. For instance, initially asking: Is aggressive therapy worth it? And then, somewhere along at another stage again ask: Where are we going? What can we expect? Plus—involve the parents.

I: There is a point where nurses and physicians can agree that hope decreases significantly?

R: Yes. And there is a tremendous strain on the family when they have a child with a long term chronic illness. I have seen families break up and other siblings suffer, and I often wonder if this [aggressive treatment] is the right thing to do . . . but I know the children who used to be miracle children, now grow up as normal children. So I guess we have to walk that line. If we don't push the frontiers, we won't make any advances.

**Normative analysis.** Improving the function of the health care system and improving the quality of life of the critically and chronically ill child concerns this nurse deeply. She wants to see families drawn into the decision making and even the young child listened to. She wants to see treatment decisions assessed at appropriate time periods. All of the suggestions typify a Stage IV pattern of reasoning that seeks to enhance and maintain the health care system while concurrently looking at the quality of life of the ill child and its family. Since this nurse can define some of the drawbacks in the present system, it seems only reasonable to suggest she could play a responsible role in their correction.
Case #18

Descriptive analysis. Lucid, yet critically ill patients often know when they don't want treatment, states this nurse. She is speaking of one example of this, a fifty year old professional man "who lived a couple of months in multisystem failure—he did not want to continue living."

I: He let you know?

R: He let them know, but medicine couldn't face it emotionally—to let him go. He extubated himself about four times.

I: Did he succeed?

R: No. He did extubate himself but he was reintubated in each case.

I: Was he lucid when he extubated himself?

R: He was heavily sedated and had to be restrained even though he was lucid. It was a horrible situation. He was on the ventilator with aggressive treatment until he finally died—it took him a month. It broke the heart of every reasonable person that came into contact with him. It was an emotional thing. The senior medical person in charge refused to discontinue treatment. But nursing staff, residents and interns don't have the power to get court orders or discontinue aggressive measures—but all were upset about it.

I: Does the emotional side come in often do you think, in the unwillingness to let people go?

R: Sometimes, but not often, because the philosophy is to treat. If someone has brain damage and they can CAT scan and do EEGs, decisions are a lot easier to make.

I: So people get removed from respirators, etc., once the brain is dead?

R: Brain death is pretty well accepted, but there have been cases where life support has not been discontinued because of family wishes.
I: How long could this go for?

R: Six months.

I: A brain dead person can be kept alive for six months if the family wishes?

R: In this case, the family was nice enough, but they pushed this case and pushed it with a threat of lawsuit. This man started to grow things, he smelled. He was just lying there without a neuron in his head. At the end of six months, he arrested and wasn't resuscitated.

I: What would the ideal be for the fifty year old man?

R: The ideal situation would be that he, with his terminal illness, could decide. He would be informed of options and treatments available first.

**Normative analysis.** Day upon day, nurses looked after this man whom this nurse felt wanted to be left to die. Residents and other nurses agreed with this; nevertheless, all of these people perceived the bounds of their influence—they could not do anything but continue treatment. Loyalty to the man and observance of his futile attempts to extubate himself proved heartrending. All were helpless. Desirous of improving the system by working within it, this nurse espousing Stage IV patterns of reasoning, wants to improve the way in which the system meets its obligation to the patient.

**Case #19**

**Descriptive analysis.** Another nurse, accentuating the bounds forced onto the nursing role, draws our attention to the problem that can occur when technology ceases to be a tool and becomes the medical decision maker.
R: I have had a situation where I watched in agony as a patient died and it was just horrible. This man, a post cardiac arrest was one of the worst situations I have come up against and he was lucid. I had known him for a period of a week, he was intubated. His status was too unstable for him to come off the ventilator. I then went off duty and when I came back there were reports back which the physicians thought showed, hemodynamically, that he had no cardiac output, that he basically had no heart left and his prognosis was grave. The doctors talked to the family who were exhausted, and they wanted to discontinue the treatment. They expected him to die right away and he didn't.

I: They withdrew the respirator?

R: Yes, plus the Dopamine. [But] he did fine. He had a wavering state of consciousness. The medical staff couldn't get it together about how aggressive they wanted to be with this guy. Then he was put back on the ventilator. His pressure didn't fall. He had only a few slow [heart] beats. The rest was normal. No one requested turning down the ventilator. Yet here I am carrying on, giving morphine as ordered and valium. I was giving large doses of morphine and valium every hour with booster shots of both.

I: The man was strong obviously.

R: That's what got me. Look at all I gave him—he was still struggling—you or I? I was getting really stressed at this time. I called out and grabbed a resident and a senior nurse and said, "I want something done."...What did they want me to do? Was I facilitating this for the family's benefit? At one point the patient really fought the ventilator. He was strong. We gave him more morphine—I was really distraught. I was crying inwardly because the family was at the bedside, everyone had expected him to die. Even when the ventilator was turned down he would start to fight. It was horrible to watch. Finally I made the family leave the room and made the resident come in with me and pulled the curtains. We turned off the ventilator, he was still intubated and he was gasping and started to struggle, he moved his hands and his arms and I was really, really upset. He was gasping and choking—we underestimated his ability to compensate.

I: Did the resident show any distress?

R: He could have come earlier, because I had approached him numerous times during the day and I don't think he understood
or his attention was on other things, but he was supportive in an emotional sense to me at the end he stayed with me. But I had to be really assertive to have him there.

I: What could have been done?

R: In retrospect and with hindsight, I would have given him a T-piece without morphine to see how he would do.

I: Was he ever, at any time, part of the decision?

R: I think he was left out of the decision because he would have periods of being fairly light neurologically and then go right back down. I made the resident stay with me because I didn't want the responsibility of giving all that morphine on my own. It was not clear cut, personally I don't feel he was sure not to survive. Ultimately, he would have run into trouble on the ward in two days, twelve hours and I don't know that for sure. That is the only discontinuation of treatment I have ever seen based on cardiac status.

I: Purely hemodynamic status.

R: He should have had the ventilator and the drugs discontinued slowly over three or four days giving him time to accommodate and then on to the next thing. It was poorly coordinated, it was extremly painful for me, painful for him.

I: Painful for the patient?

R: I'm sure it was.

I: What did the medical staff or the nursing staff do? Was there anything done to alleviate that from happening again?

R: It was an isolated incident, but I did talk to the head nurse about it. I was very upset about it. I approached all my higher-ups about it during the course of the day and they had trouble pinning down the medical staff.

I: What would you do now if that kind of thing happened again?

R: I wouldn't wait as long going back and forth to them [doctors]. I would be more aggressive.

I: What would your aggression include?
R: Approaching the doctors and being very firm, and if they say I will deal with it later, then I would say this man was suffering and then I will tell them I'm going to document and notify the staff man. It is not that I want to absolve myself of the responsibility as much as make sure they are aware and accountable.

I: Would you go as far as refusing to be the nurse for that patient if there was no change in the procedure or are you sure there would be a change?

R: I am pretty sure there would be a change, that it would be dealt with. I would hate to use that kind of thing but to emphasize the point that I was uncomfortable, then I would say I don't want the responsibility and I'm sure it would not go any further than than because once you did that, and they had to assume the responsibility themselves, and after you document your reluctance to be involved in that situation, they would have to deal with it at that point.

I: So you think it would be dealt with providing you kept at it, even more assertive than last time?

R: I wouldn't let it go, part of it was inexperience.

Normative analysis. Stage IV patterns of reasoning were upheld in the conflict situation, yet evidence of Stage VI thinking appears when the nurse provides information on what should have happened and what she would prefer. Right becomes a matter of conscience, a matter of what ought to happen in such cases. The patient warrants a fair trial even if his survival is limited. The disease process will dictate the outcome, not a drug. This nurse was quite adament when she described what she would do now. On principle she would act and see that another form of care was provided. Before continuing, it bears noting that, although this incident had occurred months previously, this nurse remained deeply affected by the wrong she believed had been committed: she believed that due to inexperience,
she had acted contrary to her own principles and, furthermore, contrary to principles of justice which protect the dignity and rights of the patient.

Not only how to provide responsible nursing care but also how to ensure our health care system is responsible to the public it serves are crucial questions today. Also, the rights and responsibilities of the individual require assessment. Both system and individual must find a way of working together in harmony if high quality, effective and efficient health care methods are to prevail. The final theme within the category depicting Stage IV reasoning concerns individual rights and the relationship of these rights to societal responsibilities.

Theme: Individual Rights versus Societal Responsibility

Nurses find themselves caught with diverging loyalties when they attempt to discriminate between the rights of the individual and the possible limits of societal responsibility to that individual. Because social policy and the health care system itself haven't defined the position clearly and since the system often places priority on arbitrary or unsubstantiated principles for treatment, it is difficult for the nurse to balance discrepant claims when those of the individual conflict with what seems, in general, in the best interest of a just, effective and efficiently run system. Cases verge between examples where individuals demand too much of a strained system to examples that depict a system which is unable to set limits.
Case #20

Descriptive analysis. In this example, the nurse speaks of the long term care program and the services that were promised patients. She states that initially, for political reasons, seniors were promised too much but that now it is felt that seniors should take more responsibility for themselves and that families can contribute more. When asked if families contribute or seek options prior to calling the long term care service, she comments:

R: Oh, not usually, occasionally but not usually.

I: So the tendency is to call for help prior to looking for options?

R: Yes, though people are learning and becoming more knowledgable. I think the public do not have enough knowledge. There are those that will go [and seek alternatives on their own] but there is a certain group of people who feel it is owed to them and they want someone else to take over. So there are two groups. My experience is that those who really need our services are the ones who struggle and do it on their own because they have always been independent and regardless of their situation, health, social or otherwise, they'll work at it until they just—

I: But with some there is a resistance to identify the problem?

R: Either resistance or not knowing how to.

I: This is where nursing comes in?

R: Yes.

I: So once the problem is identified, you actually see people become more autonomous?

R: Oh, yes. Oh, yes, it is delightful to work with those clients.

I: So they help you work with them?
R: Oh, yes, it is fabulous. I really enjoy it. But to have that—to encourage that happening in our health care system we have to start early in educating groups of people. And I have given talks to seniors on this. A tremendous group of people but for some reason because of the slot that seniors have been put in, they feel that other people have to make the decisions for them. My whole emphasis was that they have to do things for themselves—they are quite capable. They have lots to offer the community and everybody else. But they put the decision off to another. Now our real goal in the Health Department is to have them doing for themselves. And deciding for themselves.

Normative analysis. Remaining within a system's perspective, this nurse is showing how much she values the input of the seniors. While it seems she could be voicing Stage V values of people, she places her belief within the Stage IV context because she is reiterating a policy that has come down through the health care system within the last year.

In trying to help this seniors group to plan social and health related activities for the coming year, she found the seniors unable to take control. She felt part of the problem was due to socialization and part due to how the long term care program is set up and who sets it up, even within her own agency. She would like to see nurses managing the problem because they are the ones with the skills to assess and integrate physical, psychological and sociological data into a care plan that builds on the individual’s strengths. She speaks of the waste involved in time and funds because of conflicts between social workers, physiotherapists and nurses as they all do assessments when nurses are the only ones "who have a broad education in the three key areas, who know how to use a scientific method and
how to plan in accordance." In cases where nurses are not in the management position, she sees defensiveness build between professionals. She says:

R: Other disciplines do not understand when it is a nursing problem—they don't have the knowledge. They tend to cover everything so they give lots of assistance but don't really identify specific problems. Not to be critical, but that is the way one would operate if he or she didn't understand. So there is a waste of money because assessments aren't done scientifically plus they work toward making the client dependent forever. Consequently, there is conflict—nurses have to be very careful because it becomes very threatening for non nurses. Often when nurses want to make recommendations in a multiproblem case we are just not heard—it is just too threatening for them. Also, there are nursing consultants who could help out but they have no authority to see recommendations are carried out.

This case presents a good example of a nurse who values reasonable health care policy, who can delineate the problem and can provide ideas for resolutions but is unable to because of the way policy is set within the bureaucracy.

The next case provides an excellent example of the rights the individuals believe they have and how this belief places a strain on the health care system as well as placing the nurse in a difficult position.

Case #21

Descriptive analysis

R: Many problems arise when families will not let their elderly parents make decisions for themselves. Then I get the pressure from the family that I have to go in and do something—put them in a home.

I: Does that happen?
R: Oh, every day. I had an awful time with one yesterday. It's so frustrating. And the problem is that we do not have the time to sit down with the families and help them work it out—to work through their own guilt and counsel them.

I: Is it usually based on guilt?

R: Yes, it's usually based on guilt.

I: What kind of situation did you run into?

The nurse went on to outline a situation that affected an elderly married lady.

R: She had stresses because of marital problems as I assessed it. But in terms of her general health physically, there were no major problems. And her son and the doctor had insisted that we do an assessment because she was going to need a lot of care and help.

The problem came out that the woman felt depressed but that there were marital problems. The nurse suggested she get some support and counselling first for herself and then for both of them. The nurse said that she would make a referral or suggest to her doctor that he make a referral to a mental health team or psychiatrist, whatever she would prefer and the doctor would agree with. When the nurse left that day she believed that "no one was paying attention to the real problem."

R: They were responding to what she wanted which was to be cared for, taken care of. And people were rushing around to find ways to respond to this wish instead of finding out why she was wanting to be so dependent.

The next this nurse heard was that the lady was hospitalized and then returned home with a request for homemaker services. Before long the son phoned, "adament that she be placed right away."
R: So I said, "How did you come to that conclusion?" "Well," he said, "she just can't stay there anymore. So you have to get her to a home." And I said, "Well, are there other health problems that would warrant her being placed? How is her physical health?" "Oh, physically she's fine," he answered, "it's just old age and she needs to be in a home."

I: How old was she?

R: Early seventies. And so I said, "Old age is not criteria for placement." Then I said, "I'd like to ask you another question. Have you discussed this with your mother?" He hummed and hawed and didn't answer. So I said, "Is this agreeable to her?" He responded, "Well, she has to go! There's nothing else can be done, she has to go." I said, "For what reason?" "Well," he said, "the doctor says she has to get out of that environment, she could go to X hospital."

The son responded with threats such as, "What are you going to do, just let her die?" "You people are just going to let her die?"

R: I feel there is a crisis in terms of her relationship and that is not being dealt with—the real problem is the marriage. On discussing this problem with the coordinator, we thought of the assessment centre which has a team approach to care. So I thought, I'll mention that to the son to see if I can get past the doctor and get her the help she needs or that I perceive she needs. So when the son called back he was told this. He responded that she was going into hospital. He had got a doctor to send her into the hospital.

I: So what happened, in essence, was, I gather, a prolonging of the problem?

R: If I had had the time and he [the son] was agreeable, I would have liked to have met with him to help him come to realize what was happening in the relationship and to give him some direction and counsel on how he could work with her and support her rather than take full responsibility. But it was apparent to me that he was feeling very guilty and was trying to transfer the guilt. . . . I felt that he was going through a lot and if I could have helped him identify his own feelings about what was happening, then perhaps real work could have begun.

I: So you would have preferred to have had him come in and address the whole issue and take time to do this?
R: Yes. I think that he was not even aware of his feelings of guilt and responsibility nor that he was transferring and projecting this onto the health care system. He was just being defensive.

**Normative analysis.** This long term care nurse in taking the perspective of the whole system is using Stage IV reasoning. Her goal is to help the system function more effectively and efficiently while also assisting the son's mother to come to terms with her health state. She believed that the son could help in this; however, the problem was just being prolonged at cost to the system. The nurse was limited in what she could do. She wanted to direct the woman to the health care assessment team; nevertheless, doctor and son directed the mother to the hospital. The nurse did not succeed in placing responsibility for problem solving (with assistance) back to the son and mother because her input was bounded by both restraints on time and authority. As in the following case, the health care system is abused.

**Case #22**

**Descriptive analysis.** People use the system, states another nurse, because the "mental health system feeds itself so much." She says,

R: People become dependent on the system and this drains the system, drains everybody that they work with. They may go through ten psychiatrists being on each psychiatrist's caseload four years, then saying, "I can't have you anymore."

She says people become "psychiatric junkies."

R: The system is really strained and it just cannot continue to provide for this. I can think of right now on the ward
we have a good example of people for want of a better word I'll just call vaguely neurotic. They are not people with thought disorders at all. They are people who at one time were functional individuals in their life.

I: But they are not now?

R: No. As a matter of fact there are three middle aged women, all highly functional at one time. One was quite wealthy at one point but now she is living on welfare and another is supposedly disabled although the degree of her physical disability is very questionable—as is the third one. She has been checked out by medicine and they say there is nothing wrong and shipped her over to psychiatry which is really a blow to her because it sort of implies she is lying—trying to get something for nothing. But as part of her inability to deal with life she has been hanging around the hospital. Whenever we approach discharge for any of the three, each one comes up with a new crisis and new problems. One has used up her friends and they say she really can't come stay with them. They are tired of this dependent individual. So she is now at fifty, dependent on the system. So there is a conflict there, the system provides but how much should it provide?

I: What would you prefer happen to that woman?

R: I think the system is providing too much, yes. It has become countertherapeutic to provide for this woman. It's quite hard not to get angry at people like this because part of my own—I think it's professional and clinical judgment as well as my personal belief—that she is abdicating her personal responsibility to herself for whatever reason. So you try to incorporate that into your clinical picture of her. But at what point do we extend concern and try and formulate treatment and at what point do we say, look, it is time you got your act together and looked after yourself.

I: Is there any legal reason why she couldn't be discharged?

R: None I am aware of. I don't know if it's legal so much as clinically ethical—people like this often say, "You know, I might kill myself if you don't look after me." Very frankly, as someone working with these people, I feel put in a double bind with that kind of thing lots of times.

I: What would you prefer?
R: That people be helped to maintain their individuality, their identity and be treated by the health care professionals with the respect that is due them as individuals and be able to operate as individuals. There is a responsibility on behalf of the health care people to inform the patient, to give them as much information as they need. But I think the patients have some responsibility to maintain and seek help for themselves. I say that in light of the fact that I see a lot of people that are in the position of doing self destructive things. I recognize that we are there to help them maintain and promote healthier ways of coping with life but, you know, you also see people who endlessly seek ways of destroying themselves. I feel that there is only so far that a health care professional can go in that respect. You know, try as you might, people are going to kill themselves no matter what.

**Normative analysis.** Loyalty conflict here relates to decisions pertaining to just how much help do people deserve when they are in hospital to be treated but it seems that they are also malingering. In one sense this nurse criticizes the system because it "feeds" itself she says. On the other hand, people require respectful treatment. In typical Stage IV reasoning, the nurse seeks to maintain the health care system, to encourage optimal functioning of institutions while, at the same time, truly helping people become more autonomous yet letting them choose not to in a way that does not drain the system.

Stage IV patterns of reasoning in multiple loyalty conflict situations led to the identification of four themes. In each theme nursing problems relating to patient autonomy are described. Let us now place these problems in juxtaposition with those described in the literature.

**Comparative Critique**

Given the form of socialization which is present in the health care system and the type of policy decisions made in institutions,
nurses perceive that their right to practice as professionals is bounded by constraints. Yet, to an overwhelming degree, these same nurses would like to see the health care system function effectively and efficiently within a fair and just framework. Conflicts for nursing as depicted in these cases reflect conventional thinking at Stage IV since each nurse advocates maintenance of the health care system, albeit a more equitable one. However, when preferred solutions are elicited, evidence of Stage V and Stage VI thinking emerges; nevertheless, the nurses' main aim was to perfect the functioning of the health care system.

In citing conflict of loyalty areas under the theme of physician versus nurse and the theme of nursing rights versus institutional rights, it becomes evident how patient autonomy can be compromised when confusion regarding primary loyalties, legal rights, insufficient information or inadequate staffing arises. Nurses do, as the nursing standards document states, have a dependent function. And it is, in the main, interpretation of this dependent function that raises many of the key questions. For example, how does this function interrelate with nursing obligations? The answer provided in these cases reverts to a focus on encouraging the informed patient to participate in decisions and, as a corollary, to improving organization within the health care system so that within a set of reasonable criteria, patients can make their own choices regarding care. Only then can nurses who already have a mandate to promote patient autonomy truly fulfill their professional obligations.
Without a structure that supports this, nurses encounter dilemma situations. The ambiguity and accompanying incompatibility between what nurses believe is right and what they know is necessary in these cases creates loyalty conflicts. This type of problem constitutes a moral dilemma. Langham (1977) states that this is because conflicts arise over what is considered fair or just: value positions and belief systems clash as differing paradigms of health care vie for position. Then, the socialized expectations of others towards nurses and of nurses towards themselves, lead to a perception of bounded relevance which can contribute to what one nurse calls "moral hell". Nurses leave. The profession is depleted, often of its most able individuals—those who advocate patient autonomy. Davis (1982) has seen this happen and calls it burnout. One way to alleviate this, she contends, is to reason through the often profoundly emotional laden dilemmas from within an organized professional context. This concerned rational approach is vital. Correlatively, it can lead to clearer ideas on how to obtain adequate patient information, how to document patient care or staffing problems, and on how to assess legal issues. For instance, some actions can lead to culpable ignorance, defined by Smith (1983) as a deficiency in knowledge one should have or ought to have at hand. Other actions can lead to negligent conduct whereby lack of nursing knowledge can lead to legal liability. And nursing responsibilities are increasing to the point, states Fiesta (1983), that nurses will more often be held liable. Plus, liability responsibility, contends Freedman (1980),
is born in the chain of command by the last person who consummates the harm or, she goes on to say, to the last person who had a clear chance to prevent harm. Realizing this, one respondent noted that she did not want to be covered by a vague general statement made by another professional—she wanted to be accountable for her own actions.

Fiesta (1983) stresses that although hospitals and other hierarchical organizations can be held liable for the acts of their employees, nurses will have to become more legally accountable in the future.

The nurses' objectives are clear: their broad and deep grounding in empathy for the patient is evident; their desire to develop a sense of community and cooperative team work similar to the needs expressed by Gilligan, is ever present; plus, they are cognizant of the concrete need to provide comprehensive and equitable health care. Nevertheless, conflicting claims often lead to contrary objectives. Further examples of how and why this happens are also apparent in the theme based on the right of the patient to die with dignity.

The case examples, sadly, show how the dying seem to become objects and thereby helpless recipients of rules that state: treat as long as anything is treatable; or, treat if the technology is available. Accordingly, these beliefs lead to a denial of relationship, an ignoring of patient choice and a lack of humane caring. Taussig (1980) accedes to this view when he speaks of the "horror story of hospitals" (p. 9). He calls them combat zones where disputes occur over power, definitions of illness, and degrees of incapacity. Control, he says, is wrested from the patient: their status is
defined for them after they are compartmentalized into a disease state; hence, there is no mutuality, no interacting partner. Nurses, often unable to change the object status of the patient, do as one respondent did, she rationalized calling the treatment of a dying man an experiment. Roy (1981) believes that death has become an interdisciplinary event. He contends that death should be deprofessionalized and the dying person should be encouraged "to be the master of his own fate" (p. 17).

It is evident in the case examples that the patients and their families are not given a satisfactory explanation of the problem, of the alternatives for treatment or nontreatment, or of the prognosis. They have little opportunity to voice their needs based on their beliefs and values and have little chance of being permitted to die with dignity. Wojak (1978) states that dying patients deserve a time of tranquility, a time to accept their fate and that machinery should not be allowed to interfere with the progress of death. He goes on to say that the hospital's healing mission has been obscured and the breakdown of trust on which healing depends deepened. Now, patient consent is muted. And "consent," he says, "has always been the bedrock of ethical medicine" (p. 1).

Additionally, physical suffering and informed consent aside, when the cost factor arises, nurses are aware of the tremendous financial expense associated with prolonging a life (sometimes for weeks or even months) using numerous highly invasive life support techniques and therapies when a patient is in multisystem failure and is on a dying trajectory.
Admittedly, there are no objective standards for decision making on issues of treatment or nontreatment and there is a strong desire to save lives among health care professionals. But, saving lives, today and saving lives twenty years ago are vastly different concepts as will be that of saving lives ten years hence. It is true that health care professionals should never abandon care, yet as Riga (1981) asks: When can medical treatment cease and care for the dying begin? Likewise: How can fair and just objective standards be set forth?

These questions can only be answered from the standpoint of social and public policy decisions. Given this statement, it can be argued that policy reflects social value; therefore, what is happening in health care is a logical outcome of present day beliefs and values. This is true to a point. Nevertheless, changes are occurring and these are noted by nurses in the final theme of individual rights versus societal responsibility. Here, nurses identified cases in which the health care system has been abused because it has been set up so that it could be abused. Furthermore, now that there is a more general awareness of economic issues, social values which decry fiscal irresponsibility are coming to the fore. With these factors in mind, it can be seen how old values are being questioned, and, as Kaplan (1974) notes, social philosophies do change and these changes get translated into public policy. He reiterates the stand taken by the nurses which supports patient autonomy and dignity by stressing the need to assist, care for and support the worth of the individual, to
provide for freedom of treatment choice and, finally, to be aware of the social implications of the policies we create and how we use them. This is exactly what the nurses ask. They want workable clinical guidelines that take into account the extraordinary complex task of considering the values of all persons involved so that the integrity of each is respected.

With conventional level thinking, the pressures created by perceptions of bounded relevance gave rise to dissonance which resulted in the nurses' desire to promote positive change in the health care system. The type of cognitive dissonance experienced by the nurses in this category did not lead to strong negative emotions nor, as Festinger (1962) states may happen, to an acceptance of the status quo. It did lead to nurses consistently attempting to maintain safe high quality nursing care. Nevertheless, a lack of legal awareness and an inability to enact certain changes in the bureaucracy did lead to evidence of some of the defense avoidance behaviors of which Janis (1982) speaks. Behaviors such as rationalization, shifting of responsibility to others and denial of awareness of risks and losses for patients are present. In a few instances, several of the behaviors led to post decisional regret and, in one case, to a renewed commitment to principled thinking.

Let us now turn to case examples of multiple loyalty conflict which depict principled thinking at a postconventional level.
C. Volitional Relevance

At the postconventional level of reasoning, nurses perceived themselves to be equal members of the health care team and resolved loyalty conflicts in ways that maintained ethical and legal standards. They felt committed to supporting the competent patient's right to choose treatment or nontreatment measures. Concomitantly, with incompetent patients, nurses sought the advice of the family. Conflicts were resolved in positive ways, hence negative affective repercussions were avoided as were the dilemmatic situations that faced nurses who felt restricted by the need to conform to avoid disapproval while maintaining relationships, or to avoid the censure of authority figures in the bureaucratic structure.

Analytically, themes depicted in this category express principles founded on the interface between justice, standards, and duties, as they are encompassed in the role of the registered nurse. The following two principles are consistently upheld: first, the competent and informed individual has the right to choose treatment measures congruent with his or her value system as long as others are not harmed and society in general is benefitted; secondly, the registered nurse has the right to fulfil legal and ethical duties as espoused by the major professional documents and upheld by his or her own principles of action. Needless to say, themes of cooperation and accountability are most evident. The nurse cooperates with the patient, the family, and with other members of the health care team. Nurses are accountable
to the patient and family, to regulations within the bureaucracy which promote fair and just procedures, and to themselves as autonomous professionals.

When faced with conflicts of loyalty, nurses using Stage V pattern of reasoning gave priority to basic human rights and thereby to the values and beliefs espoused by their patients or their families. Nurses whose patterns of reasoning were backed by Stage VI thought showed an awareness of ethical principles. For example, they felt assured of the components of their role while at the same time being cognizant of the principle of justice and criteria for fairness. In each case nurses took pride in their behavior and felt they were fulfilling the nursing mandate. Let us now turn to the theme of cooperation and then, in conclusion, to the theme of accountability.

**Theme: Cooperation**

**Case #23**

Descriptive analysis. In this case, the nurse was working with a couple of young women who had Tuberculosis [TB] and were not anxious to be treated for it. She had to delicately balance the rights of the patients with the need of a society to protect itself. But she says, "I tried to establish a thoroughly positive attitude toward them and work through negotiation."

R: Negotiation pays off and I would say that maybe 75% of the time it pays off. Many times their own values got in the way of treatment. Tuberculosis has a really bad, dirty—you know—they felt infectious or they feel they are undesirable. Their friends stay away from them and cast them out. Plus they did not like a schedule.
I: They don't want to be scheduled?

R: Yes. If they choose to come in that is fine. But they don't choose to come in for their pills. And not being able to choose that with some freedom is really a hassle for them. It is a street value. Still they look for a doctor or nurse who will treat them as a human being. And I do think that people need to be treated with some dignity even in their misbehaving.

I: How do you treat them with dignity in their misbehaving?

R: Well, if they come in angry, I deal with their anger. If they come in drunk, then my experience is that there is absolutely no point in getting into an argument with someone who is drunk. So with dignity, just say, "Why not come back tomorrow?" And say it quietly, away from the rest of the people in the clinic, so they can walk out feeling that they are still intact and okay. It's just that we are not going to deal with them when they are like that. I don't let myself become victimized by argumentative responses.

I: Why not?

R: Because I think it will just promote it happening again. You know, I think society would just like to sweep this sort of person under the rug, just get rid of the problem, it's an eyesore.

I: It seems there's a problem already—these people already have a tenuous thread with the health care system.

R: Yes, they are just as likely to wander off with their TB and never have it checked. And you know, as in this case, even their partner doesn't want them to come in. Tuberculosis is relatively slow moving and an insidious sort of process. For example, in this case, two women were together, one having TB. The other woman wouldn't let her come in for her medications. But then the other one got TB and they both came in together. With support and counselling, they have 90-100% attendance. So, unless you deal cooperatively with the other significant person in the patient's life, there can be a problem. These people will not come if they feel threatened or any lessening of their ego. They need humor, cooperation, and cajoling a bit. Also, if you are not up front with them, they will not come back. So, if I know I'm going to admit one of my patients to a hospital, I will phone and see who is on call and on what days, and so I only send my patients in on certain days.
I: You actually plan what doctor will see them?

R: Sure. I find the appropriate hoops and jump through them. I have one doctor I owe many favors to. He has taken on many of my patients.

I: He will do a history and an admission for you?

R: Yes and take the patient on for the duration. It's marvellous.

I: Do your patients know you do this for them?

R: No.

I: No. Do they have a clue that they get special treatment? They must sense it.

R: Some of them do because they get into snags and I go beyond what may be—if special needs come up, I work around the rules without getting into trouble.

I: Why will you do that?

R: I like to promote the patient. The patient has a right to ask questions, to ask for good service, and for quality service. I will negotiate to an extent for my patients but then I expect them to follow through. I know that some of them get minimal care. Part of it is just caring. Like these women, when you notice something is wrong you offer to help out by talking to doctors and social workers for them. See they get admitted if they need to. I did this with the first woman to get TB and now she comes in regularly and takes iron and multivitamin pills plus her TB pills. She is trying to get well. She is off other drugs and alcohol at present. But all this took work, work with her and work with her partner. I have counselled them and seen a decrease in their self destructive behavior.

I: Is cooperating, then, what you preferred to do in this case?

R: Yes. I gave them choices of alternatives and counselled them about their problems and they picked up on it.

I: Do you think the fact that you went the extra mile, it seems, has contributed to their trust in you as a health care worker?
R: Oh, yes, definitely.

I: So you see a bond? They made quite a few positive choices for their health.

R: Yes and it was such a small effort on my part—just to do that little bit extra. Then I reap the benefits for the nine months of their treatment. You know, they will keep coming in. Their thank you comes out in their behavior. Working in this job has really made it very clear to me that you have to be in touch with these people before you can work with them. So the fact that I turn in statistics and say that my patients are averaging out to be in 85% of the time is a good stroke in itself. Other clinics average 30% for successful treatment. But to be able to walk down the street and have my clients stop and chat with me and not feel worried about it for any reason—I like that. You have to get over the barriers with these multiproblem people.

Normative analysis. Getting over the barriers in this case required the nurse's willingness to work with two women who would just as rather not be treated for TB. However, cooperation was possible and common benefit accrued. Not only did this nurse have a clear perception of her own equality and the importance of her role within the health care team, she also had a firm grasp of how important the street values were for her patients. In typical Stage V reasoning, she upheld a societal value, for example, freedom from infectious diseases, while at the same time doing so from within a cooperative framework that her patients could understand. As she notes, conflict is frequent and often the patient's need to be treated is slight, therefore, to resolve the conflict she bends a few institutional rules and succeeds in resolving the issue in a positive manner: obligations to the needs of society and loyalty to patient perspective are advanced.
In the next case, there is no need to bend institutional rules but there is a need to find a successful way to work with a patient who accepts treatment while rebelling against it.

**Case #24**

**Descriptive analysis.** In this example, the nurse discusses a young woman who has a severe eating disorder. While desiring to live and, in fact, earning a lucrative living, this woman followed an "extremely entrenched way of life which included restrictive eating and vomiting" and placed herself in severe electrolyte imbalance.

R: I sometimes wonder what is normal in society—we are certainly in a position to judge people. You know, some eccentric people fit in quite well. But here we have this person who is eccentric, does well, but has severe weight loss. She's here but do we feed her against her will? We used to force feed people. Now we manage a little better but still have to, at times, threaten that we will put tubes down and force feed. Though we have never done this against a patient's will. They either agree or they eat. But by then they are not fully rational—they are starving and have a temporary organic brain syndrome due to nutritional deficits. How can she be rational when she says she is eighty pounds and is fine? But now, we have a more positive feeling about what we are doing—we work with the patient in a way that is a collaborative effort. We work with them against this illness and say, "Now, how best can we help you?" Before, we almost had battled with them—we forced them to eat, fattened them up and sent them home. Then, they immediately went to their old behaviors. Now we are less rigid and less anxious and try to understand what is behind the problem. This girl was one of the toughest ones I've had. We worked with her, finding ways that she was willing to cooperate and we are supported by the psychiatrists on our unit as well. They recognize the nursing knowledge in this area. With this girl we looked at things in view of her history and I'd like to think we offer hope. We asked her if we could make this hospitalization different. We didn't set up the usual behavior modification program and the usual restrictions. She was asked to contribute—we put the control in her ballpark.
I: What happened?

R: She left in a couple of months. She did improve. She vomited less and had normalized her eating behaviors a lot—I believe we worked with her. She maintained her individuality and was treated with respect. We all worked for her good and tried to promote healthier ways for her to cope with her life.

**Normative analysis.** Cooperation and a more flexible attitude on the part of the nurse in this case made her feel she had found a more appropriate form of collaboration in treatment. It is obvious that she hated the older method of threats and battling over meals. The reason she preferred this united approach is couched in statements that are true to Stage V reasoning because emphasis is put on the patient's choice and the treatment plan is devised from the patient's perspective. Pragmatically, the nurse realizes that this form of planning will be more likely to fit into the woman's overall lifestyle thereby being maintained on discharge. Ideally, the nurse recognized that with the new approach her personal conflict caused by an aversion to forcing people to perform certain behaviors was alleviated.

From cooperating with patients who on some level must cohere with societal standards to cooperating with the self destructive, we now turn to cooperating with those who ask us to cooperate with them.

**Case #25**

**Descriptive analysis.** This middle aged man with cancer of the lung had a thoracotomy and ended up with very sclerosed lungs. As a consequence of this, he required continual respiratory assistance.
R: He was sent to us on a ventilator. He was lucid, helpful, and had a lovely, supportive family. Still, he asked repeatedly to have ventilator removed. He had a course of treatment with us that lasted longer than he wanted it to. He then had another lung biopsy. His lungs were completely sclerosed—it was confirmed that he would never come off the ventilator. Initially, in another hospital, he had made his wishes known. He did not want to be maintained for the rest of his life on a ventilator. He had already wanted to be taken off the ventilator. He also knew that he would rather come off the ventilator now than to die of lung cancer in a short while.

I: How did this affect you?

R: The nurses communicated concerns and were patient advocates. Actually, I had a good rapport with his wife. The family supported his decision. We persisted. We let the [health care] team know what the patient and the family wanted. Plus, it helped because the patient was fairly lucid and also he made his wishes known in writing though it wasn't an official document he had written. The nurses coordinated, facilitated, and supported what the patient wanted. This is something that is encouraged in our hospital by the nursing administration.

I: You are saying that you feel encouragement all the way down the administrative line for communicating with patients and supporting their wishes?

R: Yes, there have been improvements in nursing conditions—it is a reality. We are all trying to work for the welfare of the patient. Our goal is to ensure quality care. So we look at both nursing and medical standards. And, with the support of our head nurse, who plays an interesting diplomatic role, we do speak out when medical standards are faulty as well.

After several weeks, the respirator was finally removed and the gentleman had his request respected. The family accepted and supported the decision at each step along the way.

Normative analysis. A man who took the initiative, who wrote out his wishes, and who had a supportive family, asked for assistance.
He knew the quality of life he could expect and chose to forego life sustaining treatment. One component in his successful request lay in nursing action that advocated for his right to make such a choice. The nurse understood her patient's request and by gaining rapport with his wife determined that the family concurred with his wish as well. Then, over a matter of weeks, believing her contribution to be vital, the nurse advocated for the family's position. Giving credence to Stage V patterns of reasoning, the nurse cooperated with a family who knew what they wanted, yet required additional support to attain it.

What could have continued as a conflict was resolved appropriately. The nurse's perception of equal relevance as a member of the health care team and her belief in the value of patient choice helped her become an influential patient advocate and, in a matter of weeks, a successful one.

The next form of cooperation entails a more multidisciplinary structure. Our first case is resolved in a team conference.

**Case #26**

**Descriptive analysis.** This case took communicating skills, strategy, and planning on the part of a head nurse who wanted to resolve conflict between staff on her unit and who believes in "meaningful conferences" and in the right to die in comfort.

R: We have an old man who is ninety. He came in with pneumonia. He won't eat. He won't drink. He won't take his pills. He knows he's going to die, you see, and yet the physician was giving him intravenous ampicillin and
an intravenous drip. So the question arose, this man is not eating, he is not drinking, and there is a no-code order, what are we doing giving him ampicillin? The residents were frustrated. At any rate, then his pneumonia would resolve and he'd be okay. Then it would flair up again and he'd go back on the old ampicillin. And I said, we need to talk about this because people had differing views. So we asked the physician if he would come to a conference. Now he is not a physician who is very open to suggestion. But we told him about the patient. We told him he wouldn't eat or drink or take his pills. The resident explained that we couldn't understand why he was on and off ampicillin. The physician explained that he put him on ampicillin because he thought it would make him more comfortable. Then we discussed the IV. Did we want him to get dehydrated? We thrashed these topics around for awhile. Everyone put in their view. Ethically, we knew he was a no-code. However, our philosophy in the unit is to make all terminally ill patients as comfortable and pain free as we can—we want to help them towards an easy death. So I said, if the ampicillin is helping him towards an easy death, then we are achieving our goal. So the outcome from the physician was that as long as he had veins we should keep the IV going at 75 ml per hour. And if the pneumonia seems to be making him uncomfortable, we will give him ampicillin. Now I know other physicians would disagree. They would discontinue the ampicillin and the IV.

I: Do you feel this patient is comfortable?

R: Yes, I personally do. Though the geriatrician went through the cardex today and said, "Why don't they pull the IV?" I think that this is one of those things you just can't resolve. It is an individual physician's choice but we want to be part of it.

I: Do you feel that the patient, with the IV out, could still die a comfortable death?

R: Well, personally, I don't think so. They get a cracked mouth, a dry tongue, etc. We feel that a slow drip, as long as there is an open vein, is appropriate. Once the vein is gone, I do not believe the patient should be poked and poked. Nor do I believe a cut down should be done. But an IV promotes patient and family comfort.
Normative analysis. Comfort above all, comes first for this head nurse of a unit which receives many terminally ill patients. When she sensed conflict over just how this dying man should be treated, she called a conference. Interested team members plus the patient's physician attended. The outcome of the conference upheld the philosophy of the unit—comfort first with treatment and nontreatment measures to be decided on this basis. The conference achieved its aim, each team member knew how to approach dissenting others and knew that the man was dying with the minimum possible pain and suffering. With Stage V reasoning, this nurse believed that the patient had the right to die with dignity and that her unit has a right to function with minimum friction as they care for those who are dying. When the philosophy of the unit is questioned, the cause of the conflict requires examination.

It is worthy of note that in issues of palliative care and decisions on whether to treat or not to, or on what degree of treatment is appropriate, nurses and doctors and often the family cooperated time and time again. Such cases were all clearly terminal and they were concerned with individuals on a general medical or surgical unit. The conflict usually is initiated over, as in this previous case, issues of comfort. Additionally, the key dispute is generally focused on hydration although antibiotic treatment is mentioned quite frequently.

Turning now to our final theme, accountability, it can be seen
how nurses conceptualized the complex issues involved in such a manner that they could resolve conflicting loyalties by setting justifiable priorities and by framing the rights and responsibilities of all participants such that moral and legal standards are upheld. Each nurse perceived herself as significant believing she had volitional relevance or, in other words, believing she had an important contribution to make to the matter at hand.

Theme: Accountability

Case #27

Descriptive analysis. A nurse who is an advocate of fair practice and who is aware of the friction between medicine and nursing at present says she had recently run into a problem that stems from old assumptions on the part of physician and nurse. She says,

R: I think that we [nurses and physicians] have been brought up with the idea that physicians are more knowledgeable than nurses. I don't think that is necessarily so. And I think the younger nurses have a different attitude which is making more friction.

Nevertheless, setting aside her ideas about younger nurses, this nurse with over twenty years experience is also standing up for what she believes is accountable practice. She tells of an incident.

R: It was over a laboratory report. The head nurse looked at a lab report and the way the results were recorded it looked as if the patient was put on a drug that he was not sensitive to. So she spoke to the physician and he said, no, it was just due to how the stamp was placed on the sheet. So she said, fine, but had already mentioned the supposed problem to the patient's nurse in case she saw the physician first. So this nurse also mentioned it to the physician. He rudely responded to the head nurse, "I wish nurses would stick to nursing?" Yet I know that this head nurse had
picked up on three diagnoses that the physician had missed in one week. The physician was already frustrated with her.

I: Can you tell me what happened?

R: Well, the first time she asked him if he would come and see his patient, but he didn't accept the symptoms she reported. Finally, she had to say, "You will come see this patient right now." Yet, you know, he is an excellent physician, it was a human mistake. Possibly he was so rude as well because he comes from a culture where nurses are considered the handmaiden of the doctor. Yet she did diagnose correctly and two of the patients were going into congestive heart failure. Some of these doctors think we are trying to take over medicine. And to people like this physician I just say, "Come off it, you know, you send us up north because none of you will go and so you hand over medical functions to us; then we come out and you say, no, no, no, you can't do that." So I said, "It's about time you people made up your minds about what you want." So nurses can really be stuck, and this does hold us back from teaching patients and even from recognizing a missed diagnosis and demanding a patient be seen. We nurses have to resolve a lot of conflicts within ourselves and a lot of ethical issues within ourselves. We must take stands and demand to be part of the healthcare team. So that is what I do and say. Here, we demand conferences and they work. At first the doctors said, "I don't know how to start these things." Or, "What do we need a conference for?" But we taught them how to have one and what could be accomplished. Now they ask for them.

Still, as noted, the old assumptions die hard. Yet, as this nurse stresses, there is hope and once the idea of working together gets going, everyone benefits and, of course, most of all the patient because that is, after all, who the conference is for.

Normative analysis. This nurse espouses Stage VI reasoning because she places emphasis on providing just and fair treatment. She is committed to providing quality and respectful patient care and acts in accordance with principles that promote such care. She recognizes the need for interdisciplinary conferences and sees that
they are commenced. What is more, she facilitates this new routine in a mature and responsive way such that each team member feels his or her contribution has value. She has proven that those nurses and physicians who will work together can work together well. She has also proven that standing up and pointing out discrepancies can help destroy illusions as well as bring legitimacy to the actions nurses are capable of performing.

Another example of a need to deal with outworn assumptions was called to mind by a nurse who sees a number of seniors on her unit.

**Case #28**

**Descriptive analysis.** Assumptions can be potent forces. They can affect how we view those about us and, in particular, they can affect how we view the senior population in our society. Fighting such viewpoints, this nurse consistently reminds other health care professionals that the seniors are individuals and must be assessed and treated as such.

**R:** This actually is a laughable story, yet it is also serious. We had a family physician who admitted a lady in her nineties. She came in with a gastrointestinal hemorrhage. This lady's mind was bright as a button and sharp as a whip. This was on a Friday. Now her physician was particularly fond of her and he was thinking of putting her in the ICU. So he phoned the senior resident in ICU and asked him to come down and see her. And he comes into the nursing station and looks at her chart. Then he says to the family physician, "You didn't tell me she was old." This upset the family physician. So worrying about this lady he cancelled a weekend trip out of town. He did go see her and offer her ICU treatment if she needed it. She said, "No." She said she didn't want to go to ICU and she didn't want to be resuscitated. She said, "I don't want to have all those wires on me, leave me here, I'll take my chances. No."
And she took her chances and is now getting better. So a few days later we had a man in his mid-eighties come in for investigation of vertigo and he suddenly stopped breathing. He didn't have a no-code order so we called a code. Well, the same senior resident arrived at the code. He says, "He's in his eighties and you call a code! What kind of unit is this!" And so on and on. . . . Well, we told him he wasn't a no-code so legally we had to call one. We also reinforced the fact that the man was up and around and doing okay. "But, he's old," says the resident. So, a few days later we get a patient up from emergency. She had a transient ischemic attack plus she had a long term chronic illness. Nevertheless, a very good physician saw her in emergency, said she was stable, and sent her to our unit. She was also in her eighties. And—she arrested. Well, we called the code and—it was the same guy! Oh, he was furious! We resuscitated her. He was beside himself! He then discussed the whole issue with the resident on the unit. Then, you won't believe this. We admitted a 102 year old man, his diagnosis was failure to thrive—he arrested on us. We called the code and it was the same resident again. Then—again, "What kind of unit are you running? What is the meaning of this?" I don't think he ever forgave us, I think we have the worst reputation going. But, if there isn't a no-code order, we must resuscitate.

I: Did any of these people warrant a no-code order?

R: Well, the lady from emergency probably did. But I don't necessarily think that the 102 year old man did. Who are we to say—he was getting around, quality of life was there. Nevertheless, this other resident wanted to make dictates at certain ages. He didn't feel there was a point after a certain age. Families must be asked also. We are, in fact, asking more and more families now and the patient, too. This code-no-code issue is a dilemma for nurses now. Codes are stressful for nurses and they are rarely successful. We all wonder if we could have done more. We don't talk it over. It's a big ethical question. Nurses are nervous about it—they're scared. We cannot let patients die unless the physician has written a no-code. We all need to be part of this. The patient doesn't need an anxious health care team. These patients need people around them who can relax, be themselves, and can care about them without constantly being on edge watching for symptoms that require a code to be called. Yet not all older people should be no-codes.
She adds that people must be viewed as individuals and one cannot always assume quality of life is low if someone is of a certain age. She can laugh now at the resident's assumption, yet because she sees many more seniors than he does, she can respect the rights they have to be individually assessed and asked what they prefer. She has initiated more and more family involvement on her unit and is encouraging responsible family input.

**Normative analysis.** Empathy and the ability to see through competing claims to the central issue helps this nurse focus on the inherent value of the individual and to ignore inappropriate assumptions. She, true to Stage VI thinking, respects the individual. She is working toward a resolution to the code, no-code conflict that places emphasis on quality of life so that it is just for all involved. And, she stresses, we must communicate this need to step forward to the nurses on the unit, then we will have more cooperation. Because, she adds, "sometimes you have to have a conference just to defend your professionalism and to defend your rights as a nurse as well as your legal rights."

The final two cases depict independent, accountable action by nurses who believe they are significant members of the health care team. Their loyalty is to the patient. They have set clear professional guidelines for themselves and can, in conflict situations, decide how to resolve issues in ways that support patients.
Case #29

Descriptive analysis. Because this nurse knew she had the knowledge and experience to identify hyperactivity and because she saw the young child creating havoc in the classroom frustrating teachers and causing disturbances at home, and since nothing was being done for the child, she decided to push for diagnosis and treatment. The push took two years worth of effort. She describes the ordeal.

R: I believe in encouraging parents and children to help themselves with their problems. In this situation I identified a child who was having difficulty at home and in the classroom. So I talked to the parents and to me it seemed we had a case of a classic hyperactive child. Over the next year I took the Mom literature and I also gave literature to the teacher and spoke with her. They both agreed that, yes, this child is hyperactive. So, then, I encouraged the mother to go to her family doctor and ask for a referral to either of two doctors who know a great deal about hyperactivity. Well, the family doctor didn't know the child that well and didn't take the parents seriously. So the school staff and myself sent him a letter about the child's behavior and asked him to refer her. So he did. But the problem was that this specialist did his assessment and then sent her to another specialist who did his assessment. And everything is left there. Meanwhile the child's behavior is wild every day at home and at school and nothing is done.

I: With two assessments?

R: The assessments were done and reports were sent to the school. The first report diagnosed her as hyperactive but this specialist recommended that she go for psychological educational testing. So she then got educationally tested with the usual results that she functioned at this level for reading, this for writing, etc. However, the first specialist did not take responsibility for treating her nor did the second. So I got back to them both and said, "Thank you for your reports but what are you going to do about the child?" Both responded that treatment wasn't
their responsibility. So I went back to the family doctor. But he doesn't know anything about hyperactivity or ritalin or dexadrene. Nothing is done! The child is still wild! Finally, just when I was getting my most frustrated and planning my next move, we hired a new psychiatrist at the health unit. He deals with children and has had experience with hyperactive children. So I take the case to him. We start a treatment program. Now over a year and a half later, she is starting on a treatment program and it may take up to six months for her to really notice the benefits so it will be over two years of effort before initial results. And you know, the family was great. They made trip after trip to their physician. They picked up reports, they delivered them—they were excellent. But we all were not considered autonomous enough or knowledgeable enough by these specialists. Not the parents, not the school, and not myself. Plus the specialist sees the child but the report doesn't get typed and mailed out for two months after that. Then, the child waits three months to see the second specialist and that report takes another two to three months. And then each specialist sends a report to the other but neither may send a report to the family doctor. Moreover, the parents only get a copy if they push and become very assertive and they even have to push harder to get a copy sent to the school or the health nurse.

I: And your goal was?

R: To help the child control her restless behavior so that she could sit for longer periods of time in the classroom and be able to absorb more of what she should be learning. Plus to help her and her family at home with their problems with her restlessness and sleeplessness, etc. Finally, within the health unit, we have dealt with it. The psychiatrist is following her month by month and taking responsibility for prescribing correct dosages of medication. I work with her and have been working with her both by bringing her books, reading with her, and mainly talking with her about how she feels and how she's doing trying to encourage her to understand her behavior a bit. I used to see her weekly.

I: So someone was there pulling for her and helping her.

R: Yes—it took a lot of educating on my part to teachers and parents. I coordinated the whole mess and really tried to ensure that the family maintained a good relationship with their family doctor throughout this.
I: That was quite a nursing role.

R: Oh—huge! But I was convinced I was right.

I: Just hypothetically, if you hadn't been so convinced, do you think you would have—

R: Given up? Sure.

I: I wasn't going to say given up but, would you have been a little less forthright in pushing forward for the child?

R: Sure. I would have just accepted that the specialists had more knowledge. And I guess I would have just, probably gently, not connected with the family or would have gradually withdrawn figuring it had been handled. But this is one of the cases that has made me feel very good. I am a professional friend to that family and the child is really close. She knows the nurse in the school, she likes her, and she visits her office. The family have coped well. There is not much negative emotional aftermath for this child.

I: With the knowledge and the loyalty you felt to the child you met your obligations even through extremely frustrating times.

R: Yes, I had the whole community to deal with. But, the key thing too is, that this family was willing to accept some of the responsibility once they had some direction. We worked together for a positive goal—they wanted to see change as well.

Normative analysis. This nurse showed Stage VI reasoning when she decided not to maintain a status quo within the health care system. She was more interested in advancing the welfare of this child, the family, and the teachers in the school. Once she knew she had home and school behind her, the nurse determined a fair way of reaching a more positive outcome for the child.

The concluding case speaks again of the ability of a nurse to analyze a situation, to take independent action, and to meet her obligations to patients in an accountable manner.
Case #30

Descriptive analysis. Complaining at work is often a nurse's way of dealing with unsatisfactory work habits or incompetent behavior of other health care professionals states this nurse. However, when a physician could not provide logical scientific support for a treatment measure he was using, this nurse took the matter in hand and formally did something about it.

R: Yes, we complain at work to each other. Generally, we have a session just to let off steam. I think there is validity in that. If you first of all let people let off steam, they can then become objective. Then we sometimes leave it, or if it is causing problems for a patient we take it further. And there are avenues to go through if you feel strongly enough about quality of patient care. In this instance, I questioned the competency of a psychiatrist on staff. His level of functioning is poor at the best of times. Even patients have remarked over this to me which is a whole other dilemma. But I am quite open with patients, I tell them to tell their doctors and that they definitely have the right to request another psychiatrist. I feel comfortable doing that and I think it is ethically sound. But this man is not accountable. He will even hedge on ordering and say to us, "Just give what you want." Well I refuse and tell him that he is my consultant and that he must order. However, this issue has to do with a fairly bizarre treatment approach he used. One that is unfounded within recognizable treatment parameters. Anyhow, he was using this one approach which was based on the patient receiving electroneural stimulation. He insisted that this stimulation would cure almost everything. You name it, it will cure it. Well, being a thinking individual, I think this is a bit far fetched. And I was not the only one who thought this. Other staff did also, including the doctors. Now he keeps on insisting that he wants to use this on all the patients on the ward—it was getting to the point where all his patients were wearing this apparatus. And it was just too much out of 1984. And I don't feel comfortable using these things. First of all, I don't know anything about them. If they are good or not. I mean, Lord knows, they may be the answer. I don't want to deny these people health if it is going to be helpful. But I wanted some
more information on it. And he wasn't forthcoming with any. He just sort of threw off these vague generalizations about how wonderful they were and I didn't feel I was getting any satisfaction. I went to the head nurse who was feeling equally frustrated. But she has not had a positive relationship with the director of our unit, a psychiatrist, and didn't think he would do anything about it so she wasn't going to him. So I phoned the nursing practice consultants at the RNABC. She gave me excellent advice on how to deal with complaining about a colleague in the work place that you feel is not providing adequate care. For instance, you don't complain about personalities, you complain about actions. So from this, I clarified my professional concerns. Then I drafted a letter and sent it to a number of people in the department. I documented the problem, I asked for a response and I said that I would take further steps if something wasn't done. Funny enough, others agreed with me.

I: But they were letting him do it?

R: Yes, here and on other units throughout the hospital. They were letting him do it. No one was stopping him. And finally, as a result of my letter, he was told to stop. So for one and one-half years he was using this apparatus. After it was over, three other doctors told me they agreed he should stop using it.

I: Nobody knew if it was a scientifically substantiated treatment but you followed through on it?

R: Yes. But I did learn something from writing this letter. Probably another time I would involve more of the nurses on the unit. They knew I was doing this, but I would have liked their support on paper.

I: You would like the group support and group strength?

R: Yes.

I: Did you get any negative feedback from your independent approach?

R: No.

I: From the psychiatrist himself?

R: No. I talked to him about it before I ever wrote the letter. I felt I was representing other nurses and other patients.
He could give me no answers, no documentation and only responded with anger. In fact he even said things like, "How old are you anyways?" And, "How long have you gone to school?" I felt I had tried. And I felt good about my approach. I even feel better about working with him now than I did before. I feel that I am a lot more open with him now and he knows that probably if I do object to anything, I will be quite open about it with him. But I have to be careful I don't cloud my view of him over this. I shouldn't question him where I wouldn't question others just because of this. I try to be clinically objective.

I: Do you think society wants the nurse to do anything about instances like this?

R: I haven't given it much thought. But I don't like working in an unsafe work environment where clinically unsound judgments are made. I guess I wouldn't have thought about that question so much until the Grange Commission. But I do think nurses cover for doctors.

I: Do you think society expects nurses to cover for doctors?

R: No. I am not saying that society expects nurses to cover for doctors, but I do think that nurses are an easier target because there is still this mystique about the doctor being all-knowing and all-seeing and, therefore, capable of doing no wrong. Nurses are easier targets because there is not a mystique surrounding nurses.

I: But do you think society expects nurses to report unaccountable physician behavior?

R: Well, I don't honestly know what joe public thinks.

I: Do you think nurses expect it of themselves then?

R: I expect if of myself. I expect to be accountable for sure. Like in this instance, I had no qualms. I was not going to follow his order. I was not willing to do that and I could clearly identify that. There are a lot of ethical issues where I work and a lot of legal facts to be aware of. I always want to be proud of what I do and what I document. We really have a lot of power in these jobs, it is important to judge people carefully and document accurately—we have a great responsibility on behalf of the patient. They deserve respect and they deserve their rights and their dignity.
Normative analysis. This is an example of a fully autonomous accountable nurse who resolves conflict issues at a Stage VI level. A consistent view of what is fair and of what is just comes forward. In citing the fact that she is a thinking person who values objective judgments, this nurse is cognizant of the need for rational decision making which is grounded by respect for the individuals she cares for. She sought an ethically just solution to a conflict that had troubled a number of people over time. She was ready to actually resist the status quo and to threaten to go beyond the initial formal route of complaint. She, on principle, knew how to identify and organize an effective resolution while aware that others were unable to act. In effect, after the fact, others supported her actions and openly told her how they agreed with her. She responded to her own actions with pride—she had been accountable to self and to others.

Comparative Critique

Nurses who perceived they had volitional relevance or equality as a member of the health care team resolved conflicts of loyalty using postconventional reasoning. They autonomously and consistently ascertained what was right on the basis of community welfare or on the basis of moral principle. This prior-to-society perspective is evident because although the nurses were cognizant of the rules of the institution, they were willing to bend them or go beyond them—commitment focused on attaining fair and just outcomes for their patients. Ego concerns were not central nor were concerns based on
maintaining the status quo. Each nurse functioned from within a widened more objective and rational perspective which gave rise to the themes of cooperation and accountability.

Cooperation with the physician was evident when nurses using Stage V reasoning resolved conflicts. Correlatively, the views of the patient, when possible, were sought and became an integral part of what can be termed a contractual relationship based on cooperation for the purpose of upholding the rights of the patient and the quality of nursing practice.

Similar reasoning is evident in cases depicting the theme of accountability. Nurses seek to enhance the patient's right to self determination and to enhance the dignity of those who lack full decision making power. The final two cases express Stage VI pattern reasoning. Here, nurses, maintaining a principle of justice, were willing to fight the system in order to find just and ethical solutions for their patients.

Within each theme, postconventional reasoning combined with perceptions of volitional relevance provides an example of vigilant decision making. As Janis and Mann (1977) claim, the vigilant decision maker is flexible, seeks adequate information and is discriminately open minded. To them, the vigilant decision maker must also contend with multidimensional sets of values and resolve problems related to their own cognitions and attitudes, as well as social pressures from the milieu. In other words, social status or self esteem may be threatened. In the face of such considerations,
there is little evidence that these nurses lacked in decision making capacity. They were able to identify a problem, fill in the needed background information, speak to those involved, and find a route which promoted a positive resolution. Hasty conclusions were not evident nor did pressure from others deter the process of resolution. Accordingly, decisions were made with confidence. Manifestations of cognitive dissonance did not occur and it is reasonable to conclude that Festinger (1962) is right when he says cognitive conflict dissipates once internal harmony is established. Harmony occurs, he says, when there is a consistency and congruity among opinions, attitudes, knowledge and values.

Nurses, reasoning at the postconventional level, were proud of their behavior, acted on principle, and showed no evidence of post decisional regret. They fulfilled the nursing role in a manner which fit not only with their own beliefs about the role, but also in a manner that is congruent with statements in the ICN Code and Standards of Care documents. These nurses "maintained the highest standards possible within the reality of the specific situation" (CNA, 1980), and they knew it. Backed by the ability to function at a postconventional level, supported by the perception that nursing input was of value, these nurses functioned autonomously. Ambivalence and ambiguity were either diminished or nonexistent. Legal and ethical obligations are met. Both contractual and fiduciary aspects of care founded on the understanding of the right of the patient and
the duty and responsibility of the provider were coordinated. And this, of course, is a fundamental condition in the provider-patient relationship. What is more, for nursing, independent judgment and professional sophistication, contends Murchison, Nichols, and Hanson (1978), is a necessity. In fact, they claim that nursing has no dependent functions and that legal and ethical care can only go hand in hand with autonomous nursing practice.

Given these two considerations, it is clear to see that one way to achieve autonomous action under the present health care system is to function at the postconventional level placing value on principles which support the rights of the patient and the nurses own personal and professional integrity. These nurses, without fail, found positive resolutions to conflict: their fundamental soundness in decision making procedure is made more evident by the fact that others, even those in the conflict, supported the resolution. This latter consideration is a crucial one, states Dworkin (1978, p. 279), because in complex issues when rights are at risk, finding the better solution is a complicated process and often the answer must be "discovered", then firmly justified.

Clearly Kohlberg's contention that postconventional reasoning promotes more adequate decision making and thereby higher quality problem resolution is supported (1981). Thus, the concept of patient autonomy takes on a critical value when it is upheld on a principled level. Nevertheless, this level of conflict resolution only occurred
when the nurse perceived she had volitional relevance or equality
within the social context: a linkage of cognition and affect is
evident.

How then is the capability for rational thought influenced by
subjective affective factors? The answer to this question as it
relates to postconventional, conventional and preconventional
patterns of reasoning will be discussed next as the foregoing data
is placed within a substantive grounded theoretical framework.

Summary

The major substantive concept, perceived relevance, with its
two dimensional focus of imposed, bounded and volitional relevance,
has been examined in relation to the three major categories of
Kohlberg's theory of moral development. The examination includes
both descriptive and normative aspects and the discrepancies which
occur between thought and action in conflict situations.

Variables which contributed to the perception of relevance within
the milieu situation affected the manner in which patient autonomy
was upheld. The most severe discrepancies between thought and action
occurred when conflicts were resolved with preconventional patterns
of reasoning that are backed by perceptions of imposed relevance.
Themes of resentment, anger, and revenge depicting severe affective
stress were common. Variation in quality of decision making proved
widespread when conflicts were resolved with conventional level
reasoning associated with perceptions of bounded relevance. As
nurses tried to resolve the incongruency between requirements of professional behavior and the requirements of a system which they supported, they were confronted with the following five dilemmas: (a) relationship versus role responsibility; (b) nursing rights versus physician rights; (c) nursing rights versus institutional rights; (d) nursing responsibility and the right of the patient to die with dignity; and (e) individual rights versus societal responsibility. Although safe standards of care are upheld, exemplary care is not, nor are the nurses able to implement the nursing code to the degree they would prefer. On the other hand, conflicts resolved at the postconventional level concerning perceptions of volitional relevance met criteria fitting full professional behavior. Quality patient care reflecting adherence to standards of care and the ICN Code is evident as are themes depicting cooperation and accountability.

As can be seen, continual comparing of instances of multiple loyalty conflict as it centered on the concept of patient autonomy led to an interconnecting relationship between categories of cognitive moral development and categories of perceived relevance which is more affectively founded. It is the outcome of this interaction that resulted in varying responses on the part of the nurses. Chapter Five will focus on this interrelationship by providing a more abstract, theoretically orientated discussion of the process of conflict resolution.
Introduction

The analysis of data in Chapter Four clearly grounds the most relevant properties of the core concepts integral to multiple loyalty conflict situations and explains the resultant behavior on a thematic basis. Concrete examples of real world reactions to conflict over patient autonomy are woven into each thematic expansion. In this manner indicators for the concepts and their expression in themes are clearly illustrated and form a basis for theory construction.

The aim of this chapter is to develop the theoretical relationships among the major concepts. To facilitate a more comprehensive understanding of the substantive theory, a brief retrospective of the study purpose and an outline of definitions central to the theoretical perspective will be presented prior to a structural schematic representation of the theory, the propositional statements and theoretical narrative. Following this, principled determinants for action and implicit rules for behavior that underlie the cognitive-affective interface embodied in the concept of perceived relevance, will be described. The intent here is to take the empirical findings and to raise the discussion to a more abstract conceptual level.

Theoretical Purpose

All theoretical effort is focused on one goal (Chinn & Jacobs, 1983), the purpose of the study: to identify the patterns of reasoning which registered nurses use to resolve multiple loyalty conflicts
involving patient autonomy and to compare this reasoning with the patterns that depict a preferred outcome. Variables which affect the discrepancy or congruency between patterns of reasoning reflecting what actually happened in the conflict situation and what the nurses would have preferred, on a normative level, to have happened were sought. The core explanatory concept, perceived relevance, with its three dimensional subcomponents and respective thematic properties came forward as the major variable in the study. This core concept provides a foundation for a description of the dialectical process that intimately affects thought and action once the contextual nature of the situation is taken into account. A number of concepts interconnect within this relationship; therefore, prior to presenting a schematic view and narrative of the theory, a review of pertinent definitions is appropriate.

Conceptual Clarification

Multiple Loyalty Conflict

Any incongruency of demand or desire between patient, family physician, employing agency, personal ethical beliefs and professional ethical standards of the individual registered nurse.

Patterns of Reasoning

The level and stage of cognitive moral development as defined by Kohlberg's theory of cognitive moral development.

Decision Outcome

The conflict resolution including both the actual and preferred outcome.
**Perceived Relevance**

The view of self as it pertains to the subjective interpretation of the multiple loyalty conflict situation.

1. **Imposed relevance.** The perception of inequality based on a set of firmly held expectations.

2. **Bounded relevance.** The perception of limitations based on the need to maintain relationships or uphold rules.

3. **Volitional relevance.** The perception of equality expressed as the right to participate and to make choices congruent with self chosen ethical principles.

**Patient Autonomy**

The patient's right (or the surrogate's right) to have beliefs and values respected when making informed choices for action.

The concept of patient autonomy remained stable and congruent with the study definition. This focus comes forth clearly in such respondent statements as:

1. Patients should have as much control over their environment as possible.
2. A patient owns his or her body and has the right to refuse treatment and to discharge himself or herself from the hospital.
3. As long as it is possible, let the patient choose.
4. We must recognize that the patient is a human being and has opinions about what is going on.
5. We must support patient autonomy by finding ways to communicate with patients.
6. Patients need to be treated with the respect due them so they can maintain their individuality and identity.

So within the bounds of the quest to examine patterns of reasoning and the relationship between reasoning and mode of conflict resolution,
factors related to perceived relevance and not to the definition of patient autonomy intervene. Now let us turn to the presentation of theory.

Theoretical Perspective

Each concept and its related subconcepts are part of a structure. The interrelationships can be expressed in propositions which "outline a systematic view of phenomena by designating specific interrelationships among concepts" (Chinn & Jacobs, 1983, p. 20). Figure 4 presents a structural or symbolic representation of empirical phenomena.

Propositions pertinent to perceptions of relevance involving the cognitive and affective interface in multiple loyalty conflict situations are as follows.

Propositional Statements

Proposition 1:

(i) In cases of multiple loyalty conflict, if a nurse is capable of Stage IV or V reasoning and if she perceives herself to have imposed relevance, then the conflict will be resolved with Stage I or II patterns of reasoning.

(ii) Under these conditions the emerging themes of resentment, anger, and revenge grounded in the affective domain lead to symptoms of severe cognitive dissonance and result in unsatisfactory patient care.

Proposition 2:

(i) In cases of multiple loyalty conflict, if a nurse is capable of Stage IV, V, or VI reasoning and if she perceives herself to have
FIGURE 4. MULTIPLE LOYALTY CONFLICT: COGNITIVE-AFFECTIVE INTERFACE
bounded relevance, then the conflict will be resolved with Stage III or IV patterns of reasoning.

(ii) Under these conditions the emerging themes take on dilemmatic proportions with losses noted in the quality of patient care.

**Proposition 3:**

(i) In cases of multiple loyalty conflict, if a nurse is capable of Stage V or VI reasoning and if she perceives herself to have volitional relevance, then the conflict will be resolved with Stage V or VI patterns of reasoning.

(ii) Under these conditions the emerging themes of cooperation and accountability show a balance of cognitive and affective capabilities such that nursing behavior leads to high quality patient care.

**Theoretical Narrative**

The process determining the manner in which the conflict is resolved rests on the perception of relevance, and action occurs in relation to whether relevance is perceived as imposed, bounded, or volitional. Each of these categories is correlated with the level of cognitive moral development, which expresses the underlying reasoning contributing to conflict resolution, and these categories are juxtaposed against a normative level of reasoning, which expresses thought underlying the preferred conflict resolution. The result of the discrepancy is expressed in terms of themes which expand on the properties of the outcome respective to each dimension of perceived relevance.
We now want to answer our study question and also the question in Chapter Four which asks: How is the capability for rational thought influenced by subjective affective factors? In other words: What are the underlying patterns of reasoning which serve to substantiate both the actual and preferred decision outcomes? It is evident in Figure 4 that while capable of taking a normative perspective of Stage IV and V certain respondents made choices which reflect Stage I and II patterns of reasoning. Other respondents capable of Stage IV, V, or VI reasoning responded behaviorally with reasoning depicting Stage III and lower quality Stage IV thought. Nevertheless, conflicts were resolved positively and patient autonomy was upheld as was professional practice. A group of respondents who perceived that they had volitional relevance maintained Stage V or VI patterns of reasoning. Thought and action remained congruently connected.

Our question is not new. Piaget in the 1930s began, to a certain degree, asking about this relationship. Feffer in 1959, 1966, and 1970 reports on research in the area. Kohlberg (1981) addresses the question as do Shapiro and Weber (1981) who speak of the unsolved quandry. Selman (1980) reflects on the same problem. Zimilies (1981) captures the essence of the question well when he states that the construct of cognitive-affective interaction occupies a strangely contradictory position in current psychological theory and experimentation, because the way in which thought and emotion influence each other has seldom been subject to systematic study
and is most difficult to research on a quantitative basis (Shapiro & Weber, 1981).

What happened? Let's look first at the postconventional thinkers who did maintain their normative standard behaviorally. Although this study does not identify a full range of internal and external variables that lead to perceptions of volitional relevance, one thing is clear. These nurses chose to claim equal status within the health care setting and felt that they could contribute to patient autonomy. Their behavior, founded on Stage V and VI patterns of reasoning and sustained by personal and professional standards, was consistently self-affirmed when pressures within the social situation forbode of negative consequences. How, then, does the perception of volitional relevance relate to these facts? We can hypothesize that personal standards for performance were strong enough to overcome contingent pressures within the milieu. The values espoused by the nurse utilizing Stage V or VI reasoning were valued both cognitively and affectively to such a degree that even an expectancy of adverse situational consequences could not deter the nurse. Concomitantly, it is also possible that the ideal of cooperation and accountability, attained with initial risk, was a goal worth pursuing—that the incentive to reach this level of functioning professionally provided a considerable motivating force. In other words, the immediate positive, situational consequence of dropping the matter or ignoring the problem was not strong enough to deter action aimed at a longer
term, higher level goal for patient and for self. We cannot know whether these statements are facts. However, such a position is congruent with the social perspective embodying Stage V and VI reasoning because the more integrated into the personal-professional personality structure and the more valued this level of reasoning is, the more likely an individual would be to plan for and focus on behavior that would promote harmony between thought and action, or, more specifically, focus on behavior that could resist subtle or not so subtle pressures in the milieu.

Finally, we cannot know for certain from the data what the nurse's incentive or motivation for maintaining postconventional thought patterns when faced with multiple loyalty conflict is. We can only speculate about the relationship between (a) how relevant a nurse perceives herself; (b) the level of cognitive moral reasoning she is capable of; and (c) the degree of environmental support. Each respondent who resolved the conflict with Stage V or VI patterns of reasoning experienced interdisciplinary cooperation within the work setting, perceived her contribution to be valued and, on a professional level, valued responsible and accountable behavior. Correspondingly, stipulations within the Code and those substantiated within the Standards of Care were upheld to a remarkable degree.

Next, let us turn to the central features embodied in multiple loyalty conflict as it is represented at the conventional level with perceptions of bounded relevance. By definition, the reasoning
associated with conventional thinking centers on sustaining rules and regulations. When such rules and regulations and their supporting policy statements are vague, inappropriate, ineffective or even disregarded, nurses were faced with conflicts that took on dilemmatic proportions. Although each nurse, when faced with a dilemma, appeared capable of Stage IV or higher patterns of reasoning and seemed to genuinely desire to maintain directives from the Code and to function congruently with principles supporting standards of care, a certain unwillingness to take a stand became evident. This response did not threaten the legal standard of care. It did threaten the quality of care because the resulting ambivalence regarding action and ambiguous nature of priority in loyalty left the nurses unsure of their own rights. Ethically they were in a quandry. The perception of bounded relevance presented a problem because the foundations of the system and bureaucratic structure were not designed or were not perceived to be designed to promote nursing rights or nursing accountability. Thus, this bounded status compromised both nursing action and patient autonomy. This compromise is expressed in five themes. They are (a) relationship versus role responsibility; (b) nursing rights versus physician rights; (c) nursing rights versus institutional rights; (d) nursing responsibility and the right of the patient to die with dignity; and (e) individual rights versus societal responsibility.

Given that the nurses at this level were capable of conventional and postconventional thought and that they resolved the conflict by
applying a lower quality of conventional reasoning, what variables influenced the resolution process? In answer, one facet of this problem seems indisputable—nurses did have a reasonable grasp of the concepts, both ethical and legal, that underlie nursing practice. And a number of nurses showed evidence of having a substantial knowledge base in their area. Within the environmental context they were well aware of what was expected of them by others. This particular awareness proved to be a potent force contributing to the way in which they organized the parameters of the conflict. For example, defense avoidance traits emerged and nurses used buffering or rationalization in order to cope with the dilemma. In short, their cognitive and affective functioning was influenced by the structural and social underpinnings within the environment. Yet this constraint did not provide sufficient grounds to negate adequate care but quality of care did suffer. However, all nurses hoped that structures and social relationships could change for the better, resulting in reciprocal changes in nursing practice.

Completing the narrative, let us now discuss the process of conflict resolution from the perspective of those who functioned under perceptions of imposed relevance. While capable of Stage IV or V patterns of reasoning these nurses resolved conflicts using Stage I or II reasoning. Central to this conception is the perception of inequality compounded with the feeling that nurses function as the means to the ends of others. Passive behavior was common as was
acquiescence to the demands of others which led to behavior highly incongruent with the nurse's own standards. Cognitive dissonance, an attempt to normalize inconstancies, arose as did the desire to avoid unpleasant situations, elude punitive consequences and rationalize reasons for or against behavior. Feelings of inadequacy and anxiety led nurses to perform or ignore factors that would contribute to the wellbeing of the patient and to the enhancement of their professional practice. They were governed by what Pennock and Chapman (1972) term dispositional coercion. In these cases people are faced with negative sanctions if they do not perform as expected: "Individuals are treated," state Pennock and Chapman, "as things governed by causes rather than a person guided by reason" (p. 146). And with numbing regularity nurses who were capable of choosing a more positive approach permitted instances of unethical and unsafe treatment for their patients. However, decisions to not act in these cases remain decisions. The knowledge that egocentric self preservative values overcame values promoting nursing obligations to the patient led to the emergence of themes of resentment, anger, and revenge. Hence, the essential flaw or key determinant underlying the regression in patterns of reasoning appears, at least partly, to be due to the environmental authority structure and its powerful effect on the nurses' perceptions.

Principled Determinants for Action

Cognitive and affective determinants contributing to perceptions of relevance affect how obligations to the patient, family, physician,
employing agency, professional standards and personal ethical beliefs are constructed when conflict occurs. Table 1 represents a conceptual breakdown of the inductively derived variables, expressed in terms of principle and rule, which typify the central focus associated with decision making in multiple loyalty conflict situations. The principles refer to those fundamental assumptions grounding the cognitive-affective interaction for each dimension of perceived relevance. The rules signify regulating criteria which exercise control over behavior (see Table 1).

It is these principles and rules with their respective moral cognitions and affective interconnections that reflect perceptions gained from the past. They contribute to perceptions of the present and thereby offer an explanation for the way in which patient autonomy is upheld. What is more, it is the perceptions of relevance that determine the manner in which the code of ethics and standards of care are interpreted in nursing practice.

Summary

It can be seen that cognitive patterns of reasoning on a moral level are related to perceptions of relevance and their subsequent affective repercussions. The perceptions themselves are associated with principled determinants and rules for action resulting in varying modes of conflict resolution. As well, each mode of conflict resolution reflects behavioral outcomes which maintain varying degrees of patient autonomy because on a normative basis each nurse understood
Table 1
Principled Determinants for Action

Imposed Relevance - Preconventional Level

Principle:
1. Blind obedience to rule is the relevant factor in decision making.
2. Obligations have an order of priority: first, obedience to overt and covert rules within the milieu; second, to self protection; and third, to patient autonomy.

Contributing Rules:
1. Nurses who take a professional stance are not supported.
2. Nurses do not interfere with physicians.
3. Nurses do not inform patients of their right to quality care if quality is not maintained.
4. Nurses will compromise their ethical stand.
5. Nurses will avoid issues in order to keep emotionally stable.
6. Nurses fear repercussions.
7. Nurses will cope with their cognitive-affective conflict.
8. Nurses will avoid punishment.
9. Treatment is to be given if a treatable cause exists.
10. Treatment is necessary at all cost.

Bounded Relevance - Conventional Level

Principle:
Stage III
1. The need for relationship and right action is equatable with relationship maintenance.

Stage IV
2. There is an unresolvable disparity between what nurses believe to be right and what they know to be necessary.

Contributing Rules:
Stage III
1. When a patient is inadequately informed a nurse does not interfere.
2. A nurse is not legally responsible for a patient’s lack of knowledge.
3. Obligations to patients are based on relationship-promoting components only.

Stage IV
4. Dependent nursing functions take precedent over independent and interdependent functions.
5. The medical or administrative value system overrides the nursing value system.
6. Patient status is defined by other professionals.
7. Disease states take precedence over individual uniqueness.

Volitional Relevance - Postconventional Level

Principle:
1. The competent and informed individual (or appointed surrogate of the incompetent) has the right to choose treatment measures congruent with his or her value system as long as others are not harmed and societal resources utilized in a fair and just manner.
2. The registered nurse has the right to fulfill legal and ethical duties and obligations as they are outlined in the ICN Code and Standards of Care.
3. The registered nurse has the right to and is responsible for upholding her own standards and principles for action.

Contributing Rules:
1. Individuals will be treated in a just and fair manner.
2. Legal and ethical rights of the patient will be upheld.
3. Legal and ethical rights of the nurse will be upheld.
4. Professional pride is of great value.
5. Accountable nursing action is a necessity.
6. Interdisciplinary cooperation is to be encouraged.
7. Standards of care within the institution are to be maintained.
8. Rational and objective decision making processes can be instituted.
9. Nurses are independent first, then interdependent.
10. Nurses do not have a dependent function.
and valued the concept of patient autonomy. Hence, each nurse had the potential for resolving multiple loyalty conflicts from within a framework that acknowledges the value of patient autonomy and recognizes the guidelines from the Code and Standards.
Chapter Six: Summary, Conclusions, Implications and Recommendations

Summary

The depth and breadth and diversity of obligation faced by the registered nurse in the clinical setting results in multiple loyalty conflict and calls for more than excellent clinical skills, more than competence in the area of interpersonal relationships and communication; it calls for critical thinking based on a level of personal and professional integrity that many nurses aspire to yet few consistently attain. This integrity is founded on principled thinking and is backed by perceptions of equality within the interdisciplinary health care setting. Such a focus tends to promote nursing's independent function by ensuring accountability while at the same time enhancing the interdependent role by increasing interdisciplinary cooperation. When this occurs, patient autonomy is responsibly upheld.

The purpose of this study was to explore how patient autonomy was upheld in conflict situations. Specifically, the study was designed to explore the patterns of reasoning which registered nurses use to resolve multiple loyalty conflicts involving patient autonomy and to compare these with the patterns of reasoning that depict a preferred or normative outcome.

Exploring how conflicts are resolved plus the reasoning which supports the conflict resolution and comparing this reasoning with
a more objectively considered normative viewpoint requires a qualitative research approach. Grounded theory with its emphasis on comparative analysis of concepts derived from empirically based data and its requirement that theory must be substantively based proved appropriate.

A method of intraprofessional referral was utilized for selection of eleven registered nurses. Each respondent read a letter of introduction and signed a consent form prior to being interviewed. Six nurses had two, one and one-half hour interviews and the remaining five had one, two-hour interview. Six nurses graduated from diploma schools of nursing, four had their baccalaureate in nursing and one a master's degree in nursing. Of the eight nurses who worked in hospitals, four were staff nurses, two assistant head nurses, one a head nurse, and one an assistant director of nursing. Of the three nurses who worked in the community one represented long term care and the other two the prevention program.

The number of respondents and the manner of selection serves to limit the generalizability of the findings; nevertheless, since aspects of the findings do substantiate concerns voiced by Davis and Arskar (1978), Crisham (1980), Ketefian (1981a, 1981b), and many other authors mentioned here, they can provide useful input for those who are committed to supporting nurses in their quest for professional standing.

Findings are substantively grounded in the core concept of perceived relevance. The three dimensions of this concept, imposed relevance, bounded relevance, and volitional relevance, describe an
interrelationship between the cognitive and affective domain. This interaction is viewed in a dualistic fashion as the patterns of reasoning in the actual conflict resolution are compared with more objective normative reasoning. The result of these relationships led to the derivation of themes within each dimension. It was found that the greater the disparity between the normative reasoning and the reasoning that supported the actual outcome, the greater the dissonance experienced by the nurse.

Themes of anger, resentment, and revenge based on perceptions of inequality or imposed relevance depicted the greatest dissonance. Regression in reasoning ability and decision avoidance strategies occurred as nurses retreated using self protective subordinate and passive behaviors. Ethical and legal standards of care were not maintained. As the disparity between preferred and actual outcome lessened in another set of conflicts, nurses noted an awareness of limitations due to implicit or explicit rules and regulations. This dimension was termed bounded relevance because the institutional policies and procedures were perceived to not support patient autonomy and were geared to nursing's dependent role. Themes depicting dilemma situations and much frustration arose in five areas. Dilemma resolution often resulted in a lowering of quality care since nurses respected the system's perspective. Nevertheless, basic minimal standards of care were maintained. On the other hand, when reasons supporting the preferred and performed action harmonized consistently,
nurses perceived they had volitional relevance of an equal right to professional practice. Functioning as equal members of the health care team, this group of nurses demanded high standards of care and used internalized personal and professional principles to guide their actions. They experienced pride along with feelings of responsibility and competence. Themes of interdisciplinary cooperation and professional accountability came forth.

Nevertheless, each group of nurses believed in patient autonomy. Each nurse believed that patients should, within reason, control their own environment, select their own treatment from among suitable options and control their own process of nontreatment. All nurses agreed that the patients have the right to be respected and to maintain their own individuality and identity as long as their choices are supported by fair and just health care practices. Yet while all nurses shared this view, when placed in conflict of loyalty situations, only a few could participate in resolving the conflict in a manner that did indeed uphold their view of patient autonomy. Other nurses upheld patient autonomy to a degree that lowered the quality of patient care while a few found that patient autonomy was nonexistent.

Each group of nurses, following a combination of cognitive and affective perceptions, functioned from within a different framework of propositions, principles, and rules. Clearly, only one set of nurses upheld directives from the ICN Code. These considerations led to the conclusions as listed.
Conclusions

1. In cases of multiple loyalty conflict, if a nurse is capable of Stage IV or V reasoning and if she perceives herself to have imposed relevance, then the conflict will be resolved with Stage I or II patterns of reasoning. Under these conditions the emerging themes of resentment, anger, and revenge grounded in the affective domain lead to symptoms of severe cognitive dissonance and result in unsatisfactory patient care.

At this time two principles direct the nurse's action:

a. Blind obedience to rule is the relevant factor in decision making.

b. Obligations have an order of priority; first, obedience to overt and covert rules within the milieu; second, to self protection; and third, to patient autonomy.

2. In cases of multiple loyalty conflict, if a nurse is capable of Stage IV, V, or VI reasoning and if she perceives herself to have bounded relevance, then the conflict will be resolved with Stage III or IV patterns of reasoning. Under these conditions the emerging themes take on dilemmatic proportions with losses noted in the quality of patient care.

If the nurse uses Stage III reasoning, action is directed by a principle stating that:

a. The need for relationship and right action is equatable with relationship maintenance.
If Stage IV reasoning is used, the following principle is guiding action:

b. There is an unresolvable disparity between what nurses believe to be right and what they know to be necessary.

3. In cases of multiple loyalty conflict, if a nurse is capable of Stage V or VI reasoning and if she perceives herself to have volitional relevance, then the conflict will be resolved with Stage V or VI patterns of reasoning. Under these conditions the emerging themes of cooperation and accountability show a balance of cognitive and affective capabilities such that nursing behavior leads to high quality patient care.

Three principles direct action:

a. The competent and informed individual (or appointed surrogate of the incompetent) has the right to choose treatment measures congruent with his or her value system as long as others are not harmed and societal resources utilized in a fair and just manner.

b. The registered nurse has the right to fulfill legal and ethical duties and obligations as they are outlined in the ICN Code and Standards of Care.

c. The registered nurse has the right to and is responsible for upholding her own standards and principles for action,

Implications and Recommendations

The findings and conclusions have implications which result in recommendations for nursing education, practice, administration, and research.
Nursing Education

Given that not only nurse leaders but also the society in general is demanding more accountable action from all health care professionals, it is time nurses considered, both in the work place and in schools of nursing, the need for principled reasoning prior to action. This form of reasoning can occur within a framework of volitional relevance or one of bounded relevance when institutional philosophies, policies and procedures are designed to provide high quality professional contributions from all members of the health care team.

Education in the Work Place

Implications. Staff nurses, team leaders, head nurses, in fact, all levels of nursing administration have at one time experienced a multiple loyalty conflict situation and more than likely found themselves in a position somewhat similar to that of one of the three groups of nurses described in the study. With the legal community in the United States directing a sharper focus on institutional liability (President's Commission for the Study of Ethical Problems in Medicine, 1983) and Fiesta (1983) suggesting that nurses are facing litigation in increasing numbers, it follows that nurses must learn how to contend with the problematic loyalty of conflict area. At the least, the nursing profession must take steps to ensure that decisions are not made based on perceptions of imposed relevance backed by anxiety and the need for self protection. Each time this occurs the nursing profession becomes more vulnerable. The potential threat of legal
suit exists. The dependent, submissive role of the nurse is reinforced in the milieu. The philosophy and policies of the institution may be ignored and as well, it is possible that the administrative team up to and including the Board of Director or Board of Trustees are placed in a position of compromise.

Since an informed individual is more capable of consciously seeking objectives, selecting the most appropriate outcome and planning a method for attaining it, it follows that educative steps must be taken to correct the worse scenarios. In addition, steps to provide suitable information, to support nurses who require encouragement and to acknowledge those who prove to be the strongest role models are necessary.

Recommendations. It is recommended that:

1. The nursing department promote legally and ethically sound nursing practice by:
   a. including relevant material in the orientation program;
   b. utilizing bioethicists or nurse ethicists to help design inservice programs and ethics committees;
   c. informing the hospital administrator and Board of Directors or Trustees of the need for nurses to function from within a cooperative and accountable framework if economically efficient, effective and ethically viable patient care is to be achieved.

2. Plans to encourage an informed, active and responsible patient participation be devised with input from each of the health care professions.
3. The professional association act as a resource centre providing continuous updating on how nurses can maintain professional ethical standards by having a liaison member within each health care institution or agency.

**Education in Schools of Nursing**

**Implications.** Nurses in clinical practice are concerned with the manner in which they are resolving multiple loyalty conflicts. In fact several nurses remarked on how they wished they had been prepared to deal with these issues for only over time, coping by trial and error, had some of them developed the ability to take principled stands. It follows that schools of nursing have responsibilities in this area. Ethical content designed to develop cognitive and affective awareness of basic values is necessary. Such content can be designed so that it encourages critical thinking skills and instills a more indepth internalization of the values held by the nursing profession.

**Recommendations:** It is recommended that:

1. Nursing curriculums be analyzed and the quantity and quality of ethical content be identified and supplemented as necessary.

2. Student nurses be encouraged to be critical thinkers who have skills in assertiveness yet value accountable collaboration and cooperation.
Nursing Practice

The nursing act, standards of care and ethical codes focus on and attempt to provide guidance for nursing practice. Nursing actions, if professional practice is valued, should be congruent with the directives set forth in these three documents. In particular, the propositions, principles and rules derived from the theory of perceived relevance imply that intelligent reflection in the decision making process involving patient autonomy when obligations are deemed in conflict is inconsistent. Yet, as the respondents claimed, the conflicts remain so obvious and so pervasive. This implies that there is a need to have the issue addressed and strategies for resolution developed. Implications and recommendations will be viewed with respect to the ICN Code and the Standards of Care Document.

ICN Code for Nurses

Implications. Nurses are asked to respect life, dignity, and the rights of the individual—all individuals. Because, as the dimension of volitional relevance and postconventional reasoning implies, only when nurses respect themselves, have pride in their accomplishments and function within a framework of personal and professional integrity can they truly respect the rights and dignity of others. The following statements from the Code clarify this: "the nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit
upon the profession; plus, "the nurse sustains a cooperative relationship with co-workers in nursing and other fields"; and, "the nurse plays a major role in determining and implementing desirable standards of nursing practice and nursing education" (ICN, 1973).

The findings of this study point to one way of achieving such goals. That is, nurses who consistently maintained high personal and professional standards chose principles of justice and fairness to guide their conduct. This focus enabled them to utilize propositions, principles, and rules which brought a dual focus to multiple loyalty conflicts. First, they took a professional dispositional stand and, secondly, they gathered the appropriate data, sought additional information, then formulated a solution for nursing in a manner that promoted patient autonomy. Legal sanctions and societal expectations were upheld.

As a corollary, nurses who perceived they had either bounded relevance or imposed relevance were unable to successfully meet these standards. Resolution of various dilemmas resulted in a lowering of the quality of patient care and frustrations for the nurses. Retreats to self protective behavior by nurses resulted in failures to uphold either the code or standards of care creating severe cognitive dissonant repercussions for the nurses.

It becomes logical then to recommend a re-endorsement of the statements in nursing's Code of Ethics.
Recommendations. It is recommended that:

1. Professional associations and nursing educators develop strategies to inform nurses about the role of the code of ethics by:

   a. Interpreting the meaning of the statements so that nurses can identify multiple loyalty conflict situations and can discern how congruent their actions are with values promulgated by the Code;

   b. Increasing the nurses' awareness of the types of cognitive and affective dissonance they may experience if they fail to uphold the code of ethics;

   c. Assisting nurses to analyze the propositions, principles and rules associated with each dimension of perceived relevance so that they can evaluate their own nursing behaviors.

Standards of Nursing Practice

Implications. The CNA Standards for Nursing Practice (1980) states that "nurses value a holistic view of [the individual] and regard [the individual] as a biopsychosocial being who has the capacity to set goals and make decisions and who has the right and responsibility to make informed choices congruent with [individual], beliefs, and values" (p. v). It also says that "nurses are committed to the development and implementation of standards for their own profession" (p. v). Findings in this study imply that nurses who
maintain this commitment function with volitional relevance and postconventional reasoning, that nurses who use conventional thought and perceive they have bounded relevance in their practice are aware of this philosophy yet are unable to fulfill its demands, and that nurses who view conflict from a preconventional level and who contend they are unequal members of the health care team require considerable additional assistance if they are to gain such commitment.

Nevertheless, the majority of nurses were similar in one respect—they desired more support for nurses from within the nursing profession. They ask for standards of care that effect change in the world of clinical practice. This implies that the four standards of care are not functioning adequately as guides to nursing practice. Problems exist in implementation.

Standard I states:

Standard I Nursing practice requires that a conceptual model for nursing be the basis for the independent part of that practice.

This standard combined with Standard II which states:

Standard II Nursing practice requires the effective use of the nursing process as the method for carrying out the independent, interdependent and dependent functions of nursing.

lead to effective nursing practice.

Thus, the nursing process utilized with a nursing model constitutes a well organized and scientifically sound approach to nursing care.
Nursing interventions are directed to meeting the needs of the patient by using problem solving techniques combined with nursing knowledge and skill. Assessment and problem identification—as directed by the model—can be thoroughly documented thereby providing a rationale for the planning and implementation phase of the process. Accuracy and thoroughness in documentation provides the nurse with both legal and ethical criteria with which to support nursing actions. Without this framework for practice, nursing documentation may contain meaningless description and destroy nursing credibility (Philpott, 1985, p. iii). Indeed, as this study shows, nurses were unsure of how to utilize documentation effectively; perhaps, this is because they require a framework or model to direct nursing practice. As well, study findings had implications for Standard III which states:

Standard III Nursing practice requires that the helping relationship be the nature of the client-nurse interaction.

In particular, nurses functioning from the stance of imposed relevance were unable to provide congruent and consistent messages to the patients. The same nurses were unable to follow through with nursing support once patient participation had been elicited, plus, nurses, at times, found it impossible to share nursing input with patients or to teach the patient how to set realistic goals and accept responsibility for his or her own wellness.

Standard IV is also relevant:

Standard IV Nursing practice requires nurses to fulfill professional responsibilities in their independent, interdependent and dependent functions.
Professional responsibilities were consistently sustained by nurses assuming volitional relevance. They were upheld to a moderate degree when pressures within the milieu permitted by nurses who perceived they had bounded relevance and rarely upheld by nurses who functioned under the assumption of imposed relevance. Pressures within the milieu were perceived to be too threatening.

**Recommendations.** It is recommended that:

1. The CNA in conjunction with the provincial registered nursing associations develop strategies for ensuring that standards of care are upheld in nursing practice.

2. Nursing administrators and hospital administrators work in cooperation to develop policies and procedures that support professional practice and thereby protect both the hospital and the nurses from threat of litigation.

3. Nurses in clinical practice become more aware of their legal and ethical responsibility to implement standards of care.

4. Nursing administrators reassess the need to promote nursing practice based on the nursing process directed by a nursing model.

5. Staff nurses and nursing administrators develop plans for selecting and implementing a nursing model.

6. Hospital administrators, physicians and nurses look at the economic and humane repercussions that follow when patients are treated as passive recipients of varying degrees of highly technical, extremely expensive, painful and invasive therapies that the patient either hasn't consented to or has requested to have discontinued.
7. Nursing administrators and nurses in practice seek ways to encourage patients and families to participate in patient care so that the holistic view of an active and responsible individual is maintained.

Nursing Administration

Multiple loyalty conflicts invariably reflect back to the Director of Nursing because conflicts in obligation, over time, affect the environment of any institution or agency. And this environment can function as a support and encourage employees as a detrimental force and discourage them. At present, according to Dr. Helen Glass, the current controversies in health care (many of these in the realm of ethics) will require the nurse administrator's role to become even more significant (CNA, 1983). In fact, Dr. Glass contends that nursing administrators will be required to play a "vital" role as they contribute to the direction of health care in the future.

A position paper presenting standards and criteria for nurse administrators was developed by the CNA in 1983. Each standard reflects back to the need for nurse administrators to be innovative leaders using advanced managerial skills. In particular, findings in this study imply that criteria under Standards I to V and VIII be considered further.
Standards for Nurse Administrators

Implications:

Standard I

Nursing administration requires registered nurses with the education and experience to assume professional and corporate responsibilities within the organization.

Criteria

The nurse administrator,
3. possesses progressive nursing management experience;
4. understands the Acts and Regulations which affect nursing and health care;
6. strengthens professional self development through continuing education.

Standard II

Nursing administration represents the department of nursing in, and for, the organization and contributes to the administration of the entire organization.

Criteria

The senior nurse administrator,
3. is administratively responsible for all nursing personnel in the organization including other nurse administrators;

Standard III

Nursing administration provides a structure for the delivery of nursing care.

Criteria

The nurse administrator,
1. promotes the periodic review of the philosophy and objectives of the nursing department and standards of nursing care;
2. promotes the periodic review of policies and procedures to facilitate nursing care;
6. provides a committee structure which allows nursing staff to participate in decision-making.
Standard IV

Nursing administration provides for the selection and evaluation of human resources for the nursing department.

Criteria

The nurse administrator,

2. provides for an orientation program based on the assessed needs of the employee;
3. provides a staff development program;
4. provides an employee performance appraisal program.

Standard V

Nursing administration facilitates the utilization of the nursing process in the delivery of nursing care.

Criteria

The nurse administrator,

1. implements a system for the delivery of nursing care to meet the individual needs of clients in the context of their families;
2. provides the necessary qualified nursing staff;
3. ensures that work is assigned on the basis of client needs, and skills of nursing personnel;
4. provides for the documentation of nursing care;
5. implements a quality assurance program.

Standard VIII

Nursing administration establishes an open communication network throughout the department of nursing.

Criteria

The nurse administrator,

1. defines and maintains clear lines of communication for the department of nursing;
2. disseminates appropriate information to nursing personnel;
3. provides opportunities for nursing staff to discuss professional concerns.
Nursing administrators have a crucial role. For example, when Standard I, Criteria 3, 4, and 6 are addressed, fewer nurses feel obliged to perceive they must function from within a framework of imposed relevance. Substandard patient care will not occur. When Standard II, Criteria 3, and Standard III, Criteria 1, 2, and 6 are followed, nurses should be able to function professionally at the level of bounded relevance because the Director of Nursing will have provided for congruency between philosophy, objectives, and policy. Nursing input will be required and guidelines from nursing codes and standards will be explicitly evident. Inevitably, the principles and rules depicted in this study would change as professional responsibilities are set within a fair and just structure. Hence, policies derived to resolve conflicts would then meet the standards of each health care discipline and require patient participation.

Findings also relate to certain criteria under Standards IV, V, and VIII. Standard IV, Criteria 2, 3, and 4 ensures that nurses know what performance is expected and that they are given support and the necessary knowledge base. Standard V, if demonstrated through the use of a nursing model, guarantees that nurses have a conceptual framework for practice. This promotes skill in thorough documentation and brings in an increasing awareness of factors relevant to quality assurance. These two standards can be fulfilled if Standard VIII, Criteria 1, 2, and 4 are maintained. Development of a thoroughly professional nursing department depends on the concerted efforts made to meet these standards.
When procedures to meet these criteria were not developed, nurses in the study claim "there is no structured position for nurses" and "I don't believe anyone is representing the grass roots nurse anywhere." Subsequently, it becomes much harder for nurses to perceive volitional relevance and, consequently, easier to use defense avoidance strategies and faulty decision making techniques. Thus, perceptions of imposed and bounded relevance lead to frustration and anger which is compounded by the recognition of poorer quality patient care.

**Recommendations.** It is recommended that:

1. Nursing administrators as individuals and in groups examine the Position Paper on the Role of the Nurse Administrator in detail.

2. Standards and criteria listed here combined with other standards deemed advisable be studied with the intent to provide ongoing education courses and workshops for nurse administrators.

3. Nurse administrators network more closely with each other and their staff nurses in order to identify and find ways of resolving conflict of loyalty problems in a manner that supports professionalism in nursing.

4. In conjunction with hospital administrators, the nurse administrators examine the interrelationship among economic reality, patient responsibility, and the health care professional's role.

5. Nursing administrators seek ways to promote interdisciplinary cooperation as policies which encourage informed, active and responsible patient input are devised.
Nursing Research

Increasing attention has been given recently to nursing research aimed at improving nursing practice and resolving nursing practice problems within the clinical setting. Institutional philosophies and goals, nursing knowledge, and the type of administrative support all reflect back on the quality of patient care and the degree of professional behavior. Findings from this study suggest that foundations for conflict resolution and loyalty priorities focused on the nurses' perceptions of relevance.

Implications. Findings imply that when nurses are caught with conflicting obligations their level of cognitive ability and affective perception greatly influences how they contribute to the problem resolution. Each dimension of perceived relevance led to certain principles and rules for action which affected the ethics of the resolution. These rules and principles were at least partly formulated in response to pressures in the milieu situation. Supporting patient autonomy became a nursing practice problem: (a) some nurses suffered high levels of cognitive dissonance when their patient's autonomy was not upheld; (b) other nurses upheld their patient's autonomy as long as the implicit and explicit rules within the agency provided for it; and (c) a certain percentage of nurses functioned autonomously supporting patient autonomy even when faced with negative forces within the milieu. Consequently, these findings imply that the ICN Code is only truly upheld in the nursing practice of this latter group of nurses.
Recommendations. It is recommended that:

1. Further studies be conducted with a larger sample of registered nurses to determine the accuracy of the results presented here.

2. Studies be developed to point out more specific factors within the milieu situation that detract from nursing's support of patient autonomy.

3. Research on consumer perspectives of nurses would help nurses determine how to promote patient autonomy more effectively.

4. Studies in social economics be conducted to see if health care costs are reduced when informed patients make their own decisions regarding foregoing life sustaining treatment or highly invasive therapies.
References


Nursing Forum, 17 (1), 15.


Appendix A

Canadian Nurses Association Standards for Nursing Practice
Standards for Nursing Practice

These four standards are necessarily interdependent and interrelated.

**Standard I** Nursing practice requires that a conceptual model for nursing be the basis for the independent part of that practice.

**Standard II** Nursing practice requires the effective use of the nursing process as the method for carrying out the independent, interdependent and dependent functions of nursing.

**Standard III** Nursing practice requires that the helping relationship be the nature of the client-nurse interaction.

**Standard IV** Nursing practice requires nurses to fulfill professional responsibilities in their independent, interdependent and dependent functions.
Appendix B

International Council of Nurses Code for Nurses
International Council of Nurses Code for Nurses

Ethical Concepts Applied to Nursing 1973

The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering.

The need for nursing is universal. Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status.

Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

Nurses and People

The nurse's primary responsibility is to those people who require nursing care.

The nurse, in providing care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected.

The nurse holds in confidence personal information and uses judgement in sharing this information.

Nurses and Practice

The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning.

The nurse maintains the highest standards of nursing care possible within the reality of a specific situation.

The nurse uses judgement in relation to individual competence when accepting and delegating responsibilities.

The nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit upon the profession.

Nurses and Society

The nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public.
Nurses and Co-Workers

The nurses sustains a cooperative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person.

Nurses and the Profession

The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education.

The nurse is active in developing a core of professional knowledge.

The nurse, acting through the professional organization, participates in establishing and maintaining equitable social and economic working conditions in nursing.

Adopted by the ICN Council of National Representatives, Mexico City in May 1973. Reprinted with the permission of the International Council of Nurses.
Appendix C

Letter of Introduction
Appendix D

Consent Form
Consent Form

I have read the letter of introduction concerning this study and understand its contents.

I may refuse to answer any question I am asked or may withdraw from the study at any time.

I consent to participate and will retain a copy of this consent form.

Date:_____________________

Signature of Respondent:_____________________________________

Signature of Researcher:_______________________________________