

**TOWARDS NEW MEANINGS:
NURSES' ETHICAL PERSPECTIVES
ON NURSING DYING PATIENTS
IN A CRITICAL CARE SETTING**

by

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Abstract

TOWARDS NEW MEANINGS: NURSES' ETHICAL PERSPECTIVES ON NURSING DYING PATIENTS IN A CRITICAL CARE SETTING

This study describes nurses' ethical perspectives on nursing dying patients in a critical care setting, as well as nurses' responses to their perspectives. The design involved a phenomenological approach, with unstructured interviews with eight critical care nurses used to generate data.

The results indicated that nurses' ethical perspectives centered around a theme of senselessness; a senseless decision-making process, the experiences of patients and family members as senseless, and nurses' activities as senseless. Senselessness illustrated the multiple ethical dilemmas inherent in nurses' experiences. Nurses' ethical perspectives also involved their attempts to cope with senselessness by finding new meanings through shifting focus to patient comfort, support of the family, and to nurses' personal philosophies. The situational context of nurses' perspectives was explored in terms of influences on their perspectives.

This study supports other recent nursing research identifying prolongation of the process of dying as a significant ethical problem engendering moral distress.

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We still believe that the
world has a deeper meaning
than what is apparent, and
that therein the human soul
finds its ultimate harmony
and peace.

(Tagore, 1913/1961, p. 196)

CHAPTER ONE:

INTRODUCTION

Conceptualization of the Problem

The practice of nursing in critical care settings has evolved in concert with a trend towards specialization in the nursing profession as a whole (Baumgart, 1985; Canadian Nurses' Association, 1981; Lane, 1985). Critical care nursing has been defined as "the nursing of people undergoing life-threatening physiological crises" (Holloway, 1984, p.1). Within the context of these crises, emphasis is placed on nurses' decision-making skills to intervene in the patient's responses to illness, injury and treatment (Holloway, 1984; Hudak, Gallo & Lohr, 1986; Kinney, 1981). Characteristics of critical care nursing as a specialty include a mandate for recognition and appreciation of the individual's wholeness, uniqueness and significant relationships (American Association of Critical Care Nurses, 1981).

The evolution of critical care nursing has also paralleled specialization in the health care system with its concurrent technological innovations (Fagerhaugh, Strauss, Suczek & Wiener, 1980; Gillis, 1985; Shaw, 1984). Health care specialization has been described as creating an exploding technology that has

fragmented and dehumanized patient care (Benoliel, 1983; Fagerhaugh et al., 1980; Gillis, 1985; Kinney, 1981; Levine, 1977). Critical care nursing has therefore developed as a nursing specialty for patients undergoing life-threatening physiological crises, with a mandate to provide care to the whole patient, but finds itself operating within a system that has become fragmented and dehumanized.

Of particular concern in the application of technology within this health-care system is the underlying assumption of patient death as failure. As a result, prolongation of life takes place for many patients in critical care settings (Kiely, 1985; Weil & Rackow, 1984; Woods, 1984). Prolongation of life often involves invasive measures such as intubation, ventilation and hemodynamic monitoring, as well as constant observation and intrusion by a variety of personnel. This is best termed prolongation of the process of dying, for despite such intensive measures, many patients in critical care settings eventually die. To illustrate; in a study determining prognostic indicators, it was found that adult patients with respiratory failure requiring ventilatory support had a mortality rate of 66%, those over sixty-five years of age had a mortality rate of 85%, and patients with

multi-system organ failure had a mortality rate of 99% (National Heart, Lung and Blood Institute, 1979, pp. 19-36). Given current uncertainty in the medical community as to establishment of criteria for the application of technology, elderly patients, patients with multisystem failure, and even patients with terminal illnesses, constitute a significant number of those in critical care settings (Cassell, 1986; Elovitz, 1981; Fineberg & Hiatt, 1979; Jackson, 1984; Russell, 1983; Thibault, Mulley, Barnett, Goldstein, Reder, Sherman & Skinner, 1980). Hence, a significant number of patients in critical care settings experience prolongation of the process of dying.

Critical care nurses therefore find themselves participating in the application of intense technology despite their knowledge that a significant number of their patients will die. The costs of the application of intense technology have been described as including loss of dignity and dehumanization of nurses' dying patients (Benoliel, 1981; Mauksch, 1975; Netsky, 1979; Roberts, 1976; Woods, 1984). It is further indicated in the literature that participation in prolongation of the process of dying is stressful for critical care nurses, and contributes to their burnout and attrition (Bailey, Steffen & Grout, 1980; Cowles, 1984; Davis,

D., 1986; Dear, Weisman, Alexander & Chase, 1982; Holloway, 1984; Mendenhall, 1982; Millar, 1980).

The sources of nurses' stress are apparently not that their patients die, but rather the manner in which they die. Nurses are seen to be unable to provide ways of preserving human values of autonomy and dignity for their dying patients (Benoliel, 1981; Canadian Nurses' Association, 1985). This may reflect a conflict between the ideology of patient cure and the ideology of patient care (Benoliel, 1981). It should be noted at this point that the literature is unclear with regards to how physicians and other health care professionals are affected by the application of intense technology.

The line of argument presented thus far is that the application of intense technology to prolong the process of dying of patients is described in the nursing literature as being stressful for critical care nurses, and may contribute to their burnout and attrition. A specific area of concern is the apparent inability of critical care nurses to provide care for their dying patients that is congruent with human values of autonomy and dignity.

It is particularly relevant to consider prolongation of the process of dying in terms of an

ethical problem. Curtin (1982a) defines an ethical problem as one that: (a) cannot be resolved solely through an appeal to empirical data; (b) involves conflict of values and uncertainty about the amount or type of information needed to make a decision; (c) the answer reached will have profound relevance for several areas of human concern (pp. 38-39). In accordance with Curtin's definition, the literature previously presented reflects an ethical problem for several reasons. First, prolongation of the process of dying in critical care settings may present an ethical problem to nurses because empirical data do not support the effectiveness of intense technology for many patients, or provide guidelines for when such measures are appropriate. Secondly, a conflict has been described as existing between the ideology of patient cure and the ideology of patient care. Finally, it is indicated that decisions to pursue or discontinue the application of intense technology will have profound relevance for issues such as quality of life, euthanasia, and distribution of health care resources (Cowles, 1984; Curtin, 1982; Mendenhall, 1982; Weil & Rackow, 1984; Woods, 1984).

Implicit in the previous discussion of the ethical problem is an assumption about nurses' moral

development. Nursing is seen as a moral art, advocating universal values of human autonomy and dignity (Curtin, 1982b, Gadow, 1980/1983; Murphy, 1983). It is assumed that nurses should be morally developed persons adhering to those universal values (Cameron, 1986; Crisham, 1981; Ketefian, 1981a, 1981b, 1985; Mahon & Fowler, 1979). Nurses as morally developed persons are usually described in terms of Kohlberg's (1972) theory of moral development. Kohlberg describes optimum moral development as morality "of individual principles of conscience that have logical comprehensiveness and universality. Highest value [sic] placed on human life, equality, and dignity" (p. 15). Thus it would appear that nurses find themselves with an ethical problem because prolongation of the process of dying in critical care conflicts with nurses' values of human autonomy and dignity.

However, there is little written that actually explores ethical situations faced by nurses with their dying patients (Crisham, 1981; Davis, A., 1981; Davis & Aroskar, 1983; Fenton, 1987; Omery, 1983b; Wilkinson, 1985). Furthermore, there is some indication that moral development, and hence moral reasoning, may not be a simple matter of applying universal values. The

previously cited argument that nurses looking after dying patients in critical care will always find themselves with an ethical problem is founded primarily on Kohlberg's (1972) interpretation of universal values.

Kohlberg's (1972) theory is based on research with adolescent boys using hypothetical situations (Munhall, 1983). In critique of Kohlberg's theory, Gilligan (1977) indicates that women's reasoning in ethical issues is different from that of men. Women are described as being concerned with a morality of "responsibility and care" (Gilligan, p. 516). Gilligan elaborates on how this difference influences women's reasoning. She states that "women's judgements are tied to feelings of empathy and compassion and are concerned more with the resolution of 'real-life' as opposed to hypothetical dilemmas" (Gilligan, p. 490). Women, and hence the majority of nurses, thus may view ethical situations in a variety of ways depending on how they interpret their responsibility and care in the real-life situation (Davis, D., 1986; Gilligan, 1978; Munhall, 1983; Omery, 1983b, 1985).

The validity of Kohlberg's theory of moral development has been further questioned not only because it fails to address the morality of women.

Kohlberg's work is considered to lack cross-cultural relevance, and fails to distinguish moral choice from moral action (Omery, 1983b; Sullivan, 1977; Wilkinson, 1985). Sullivan presents his criticisms along these lines succinctly when he states:

. . . Kohlberg's structural conception of morality tends to create dichotomies when treating the relationships between thought and action, form and content, and the abstract and the concrete [he] tends to separate the 'emotional' life from the 'intellectual' life where morality is concerned (p. 15).

Therefore, individual nurses may look at each dying patient's situation in terms of how they view their interpersonal responsibility, their cultural values and beliefs, the concrete facts of the situation, . . . situational constraints, and their own feelings (Cowles, 1984; Fenton, 1987; Omery, 1983b; Wilkinson, 1985). The implicit assumption in the literature that nurses looking after dying patients in a critical care setting will always find themselves with an ethical problem conflicts with this pluralistic view of moral reasoning.

Summary of the Conceptualization

Critical care nursing has developed as a nursing

specialty within the context of a health care system that has become fragmented and dehumanized. Within that system, prolongation of the process of dying of patients is a frequently occurring process that nurses apparently find stressful and may lead to their burnout and attrition. Prolongation of the process of dying has been viewed as creating an ethical problem for nurses, with the implicit assumption in the literature that nurses will always find prolongation of the process of dying conflicting with their values of human autonomy and dignity. However, in light of a relative lack of ethical research and conflicting theories of moral reasoning, it has been argued by this investigator that we cannot assume what individual nurse's ethical perspectives will be.

Problem Statement

The literature has indicated that prolongation of the process of dying for patients in critical care settings poses an ethical problem for nurses. However, there is a relative lack of ethical research describing how nurses interpret the ethics of prolonged dying in critical care settings. Furthermore, the literature presents conflicting viewpoints in relation to nurses' moral reasoning. Therefore, the research question for this thesis is:

"What are nurses' ethical perspectives on nursing dying patients in a critical care setting?"

Purposes of the Study

Given that there is a lack of literature detailing the experiences of nurses in regard to their dying patients, the purpose of the author's study will be to describe nurses' ethical perspectives on nursing dying patients in a critical care setting. Also given that prolongation of the process of dying has been described as stressful and leading to burnout and attrition of critical care nurses, it will be a purpose of this study to work towards a better understanding of nurses' responses to their ethical perspectives.

Methodological Approach

The methodological approach for this research has been chosen to provide a full and accurate description of individual nurses' ethical perspectives. That approach has been derived from the branch of philosophy known as existential phenomenology.

The emphasis in existentialism is upon the conduct of life; the emphasis in phenomenology is upon the problems of knowledge and meaning. Each is therefore partial, by itself, but their fusion has resulted in a humanistic philosophy whose breadth is still but little known in this country (Lawrence

& O'Connor, 1967, p. 1).

Schutz (1932/1967a, 1954/1967b) pioneered the application of existential phenomenology in the social sciences. Working within a field known as interpretive sociology he stated that ". . . all scientific explanation of the social world **can**, and for certain purposes **must**, refer to the subjective meaning of the actions of human beings from which the social reality originated" (Schutz, 1954/1967b, p. 387). That social reality is intersubjective, and hence must be understood through a process of intercommunication (Schutz, 1932/1967a, 1954/1967b). Therefore, phenomenology as a methodology focuses on "experiences as shared and understood by the participants and the observer" (Rist, 1979, p. 20).

Given phenomenology's emphasis on meaning within an intersubjective social reality, the investigator feels that this approach will best explore the multiple facets of nurses' ethical perspectives, for example how nurses feel about looking after dying patients and how they interpret situational constraints. In support of this study's phenomenological approach, it is interesting to note that in Sullivan's (1977) critique of Kohlberg's (1982) theory, he states that phenomenologists have "adamantly defended" the

importance of the "concrete, idiosyncratic, and contextual" (p. 19). It is these latter qualities that the investigator wishes to explore.

The application of phenomenology as a methodology will be discussed in Chapter Three. At this point it should be noted that the choice of phenomenology as a methodology for this thesis follows a paradigm shift away from the objective reductionism of the natural sciences towards a subjective exploration of human experience (Giorgi, 1975a & b; Kuhn, 1970; Lawrence & O'Connor, 1967; Shutz, 1954/1967b; Zaner, 1978). Within nursing, phenomenology is gaining increasing acceptance as a means of studying the uniquely humanistic basis of nursing practice (Anderson, 1981a, 1981b; Benner, 1985; Davis, A., 1973/1978; Field & Morse, 1985; Knaack, 1984; Lynam & Anderson, 1986; Lynch-Sauer, 1985; Munhall, 1982a, 1982b; Munhall & Oiler, 1986; Oiler, 1982, 1986; Omery, 1983a; Ray, 1985; Rieman, 1986). It is hoped that the use of phenomenology within this thesis will further add to our understanding of the humanistic basis of nursing practice.

Operational Definitions

The following is a list of operational definitions for the terms used in the research question:

1. Nurses' Ethical Perspectives - nurses' knowledge of and feelings about their experiences caring for patients within a situational context. Includes nurses' perceptions of their moral choices and moral action.
2. Dying Patients - Patients who are experiencing prolongation of the process of dying. Prolongation involves invasive measures such as ventilation and hemodynamic monitoring as well as constant observation and intrusion by a variety of personnel. Dying will be defined in terms of nurses' understanding that the patient will not survive the critical care unit or the current hospitalization.
3. Critical Care Setting - Critical care settings include those specialized units within hospitals that are structured to deal with life-threatening physiological crises. These units include intensive care units (ICU's), coronary care units, surgical intensive care units, post-open heart recovery units, pediatric intensive care units, and neonatal intensive care units. Prolongation of the process of dying takes place most frequently

in general adult ICU's.

Assumptions

The first assumption of this research is that nursing is a moral art, advocating universal values of human autonomy and dignity. Secondly, it is assumed that nurses will interpret the ethics involved in nursing dying patients in a critical care setting according to the context in which they view the situation and their personal values and beliefs. Thirdly, it is assumed that the application of technology will continue to result in the prolongation of the process of dying of many patients in critical care settings. Fourthly, it is assumed that no one professional group is responsible for the application of technology, but rather the application results from a societal emphasis on specialization and technological innovation.

Limitations

A limit to the general application of this study will be that nurses' ethical perspectives will be explored only in relation to the ethical problem of prolongation of the process of dying. Other pressing ethical problems in nursing will not be directly addressed. Secondly, limiting the focus to critical care settings will not address nurses' perspectives of

ethical problems within other areas of nursing practice.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

Introduction

The purpose of this chapter is to provide a review of literature related to the conceptualization of the problem statement in Chapter One. Pertinent research and theoretical works will be explored to further substantiate the conceptualization of the problem statement. In Chapter Four: Presentation and Discussion of Accounts, the investigator will take direction from the accounts to re-examine the literature reviewed and to incorporate additional works to enhance the discussion.

Within Chapter Two: Review of Related Literature, the investigator will present pertinent research and theoretical works in a format parallel to the conceptualization in Chapter One. The literature review will therefore centre around the ethical ramifications of prolongation of the process of dying, and moral reasoning.

Prolongation of the Process of Dying as an Ethical Problem

Introduction

Chapter One presented prolongation of the process of dying in terms of an ethical problem. In order to

explore the ethical ramifications of prolongation of the process of dying more fully, pertinent literature will be explored in terms of related ethical issues and related ethical research.

Prolongation of the process of dying was posited as an ethical problem in Chapter One in accordance with Curtin's (1982a) definition. In order to place prolongation of the process of dying more fully in an ethical context, selected ethical literature will be reviewed at this point to clarify some relevant terms.

The field of ethics is founded in a branch of human knowledge known as philosophy. Philosophy can be defined as "critical reflection on the justification of basic human beliefs and analysis of basic concepts in terms of which such beliefs are expressed" (Edwards & Pap, 1973, p. xiv). As a branch of philosophy, ethics focuses critical reflection upon "actions and events from the standpoint of right and wrong, good and evil, moral value and moral disvalue, and . . . the resolution to seek the truly valuable in life" (Kelly, E., 1980, p. 13). Morals refer to customs or habit, and are located within a social enterprise (Davis & Aroskar, 1983, p. 2). Ethics and morals are often used interchangeably (Davis & Aroskar; Storch, 1982), although Jameton (1984) notes that "**ethics** is

the more formal and theoretical term, **morals** the more informal and personal term" (p. 5). Values can be defined as "affective disposition[s] towards a person, object, or idea" (Steele, 1983, p. 1). The field of health care ethics functions:

(1) to sensitize or raise the consciousness of health professionals (and the lay public) concerning ethical issues found in health care settings and policies and (2) to structure the issues so that ethically relevant threads of complex situations can be drawn out (Davis & Aroskar, 1983, p. 4).

Prolongation of the process of dying, then, arises in the context of critical justification of human beliefs in an attempt to determine moral value or disvalue of the performance of the health care system. In accordance with Davis and Aroskar's (1983) definition of health care ethics, this investigator will attempt to present the issues within which prolongation of the process of dying is embedded so that ethically relevant threads of complex situations can be drawn out.

The use of terms such as ethical issues, ethical problems, and ethical dilemmas is not well standardized in the ethical or nursing literature. For the purposes

of this thesis, Curtin's (1982a) definition of an ethical problem has been accepted. An important feature of Curtin's definition is the emphasis on the necessity to make some kind of decision(s).

Prolongation of the process of dying was presented in Chapter One as constituting an ethical problem, and hence is a problem that necessitates some kind of decision(s).

Ethical issue is another term frequently used in the nursing literature. This investigator was unable to locate a definition of ethical issue. Given a dictionary definition of issue as "a point of debate or controversy" (Webster's Ninth New Collegiate Dictionary, 1985, p. 642), and the previous ethical definitions, this investigator will use the term ethical issue to mean a point of debate or controversy in the determination of moral value or disvalue. Ethical issues will therefore include some of the more abstract notions within which the problem of prolongation of dying is subsumed. Drawing from a system of categorization from a recent text on the ethical issues of death and dying (Wier, 1986a), the issues of definition and determination of death, euthanasia, and treatment abatement will be addressed.

Related Ethical Issues

The intent of this section of Chapter Two is to present selected ethical issues so that ethically relevant threads of complex prolongation of the process of dying situations can be drawn out. The exploration of related issues will often overlap from ethical into legal ramifications. As noted by Rozovsky and Rozovsky (1983), law "involves the control of relationships among people whereas ethics examines what is right and wrong . . ." (p. 290). Storch (1982) observes that there is a "close, albeit uneasy, relationship between law and ethics" because legal decisions may appeal to ethical principles (p. 17), while Rozovsky and Rozovsky further indicate that ethical debate may "help to reshape the legal response . . ." (p. 291). The relationship between law and ethics is thus best termed reciprocal. The exploration of related issues to follow will reflect that reciprocal relationship.

Definition and Determination of Death. The definition and determination of death has been the focus of a great deal of attention in the legal and ethical literature for the past two decades. Given the exploding technology spoken of in Chapter One, developments "in resuscitation techniques and the ability of machines to take over such vital functions

as spontaneous breathing challenge traditional ways of diagnosing death" (Lamb, D., 1985, p. [ii]).

Diagnosing or determining death with the application of traditional biomedical criteria has thus become problematical.

In response to technological changes, the traditional biomedical criteria of cessation of blood circulation and respiration to determine death have been supplemented with the criteria of brain death (Lamb, D., 1985; Law Reform Commission of Canada, 1981; Walters, 1982b). As a consequence of the adoption of these new criteria, patients diagnosed as brain dead are usually allowed to die, sometimes after participation in the organ donation process. Those patients who do not fit the newly established biomedical criteria, however, are not defined as dead or dying. This includes patients discussed in Chapter One, who may be comatose, elderly, with multisystem failure, and an almost absolute certainty of death. Hence, the adoption of purely biomedical criteria:

leaves for future resolution the even more difficult problems concerning the conditions and procedures under which a decision may be reached to cease treating a terminal patient who does not meet the standards set forth in the statutory

'definition of death' (Capron & Kass, 1972/1982, p. 299).

Perhaps the difficulty in reaching a decision to cease treating a terminal patient who does not meet the criteria reflects a difficulty with the concept of death. D. Lamb (1985) states that "the concept of death cannot be exclusively determined by medical criteria. This is because it is related to more general philosophical beliefs concerning the **meaning** of life and death" (p. 9). Veatch (1976) also expresses concern about the concept of death. He states that "now that technology permits us to treat the body organ by organ, cell by cell, we are forced to develop a more precise understanding of what it means to call a person dead" (Veatch, p. 21).

Euthanasia. The next ethical issue to be discussed is that of euthanasia. Euthanasia has been the subject of increasing ethical and legal debate over the past two decades. The debate ranges along "a continuum of intervention for decision makers ranging from a strict 'sanctity of life' or antieuthanasia view to passive (inactive) euthanasia to active euthanasia" (Davis & Aroskar, 1983, p. 141). Along this continuum, the use of the term euthanasia is often ambiguous (Curtin, 1982c; Davis & Aroskar; Walters, 1982c; Weir, 1986c).

To examine the issue of euthanasia requires some attempt to clarify the sources of ambiguity. The continuum of intervention described above is structured on an active-passive distinction. Active euthanasia implies a direct action to end another's life, while passive euthanasia implies withdrawal of treatment measures (Walters, 1982c; Weir, 1986c).

A second distinction is between voluntary or involuntary euthanasia (Curtin, 1982c; Walters, 1982c; Weir, 1986c). Walters describes the latter distinction as follows:

Voluntary decisions about death are those in which a competent patient requests or gives informed consent to a particular course of treatment or nontreatment. The term 'involuntary', however, is not generally applied to situations in which the expressed will of a competent patient is overridden but rather to cases in which the patient - because of age, mental impairment, or unconsciousness - is not competent to give informed consent to life-death decisions (p. 308).

Informed consent implies four prerequisites. These have been described by Beauchamp (1982b) as including (a) disclosure; (b) voluntariness; (c) cognitive information-processing; (d) competence (p. 171).

In terms of prolongation of the process of dying, competence is often a prerequisite that is unable to be fulfilled by patients who are critically ill (Weir, 1986b). Determining competence is also problematical, for "many ICU patients are categorized in gray areas in which competence (or autonomy) is compromised rather than entirely absent" (Youngner, 1986, p. 43). It is therefore often difficult to determine whether the critically ill patient is competent to participate in voluntary decisions about death.

Given a determination of lack of patient competence, the patient has a right to proxy decision-making (Philpott, 1985; Picard, 1984). Proxy decision-making is frequently necessary in critical care for the patient to initiate the process of euthanasia. Proxy decision-making for euthanasia was first established in the Karen Ann Quinlan case, where the parents of a comatose patient successfully applied to have life-support measures withdrawn (re Quinlan, 1976). Curtin (1982c) offers the following commentary on the direction provided by the Quinlan case:

Given the fact that many people are involved in such decisions in the modern hospital and that each of these people must bear moral and legal responsibility for his/her actions, it is not

permissible for one person to make a unilateral decision for the death of another person. This position was given recognition and support by the New Jersey Supreme Court's decision regarding Karen Ann Quinlan (p. 231).

Curtin summarizes the conditions for appropriate proxy decision-making for euthanasia by stating that "(1) The decision must be informed, (2) The decision must be demonstrated to be in the best interests of the patient, (3) The decision must not be unilateral, that is, it must be a shared decision" (p. 232). A Canadian legal scholar, Dickens (1980) has described similar conditions for proxy decision-making in Canada. Philpott (1985), however, warns that current legislation and inconsistent policies and practices in Canada render the incompetent person "vulnerable" (p. 65).

Proxy decision-making has thus been identified as necessary for euthanasia to take place for many critically ill patients. Despite the direction provided by the Quinlan case, that process has not been well established in Canadian medical and legal practice. Furthermore, the determination of competence or incompetence of critically ill patients is uncertain. Hence, there is an uncertain mechanism for

incompetent patients in critical care to exercise their autonomous right to accept or refuse treatment.

Furthermore, at least one philosopher has argued that the active/passive distinction for euthanasia is irrelevant (Rachels, 1975/1982). Weir (1982c) finds that the "distinction between passive and active euthanasia is not particularly helpful" (p. 244). Instead, Weir posits passive euthanasia as treatment abatement, and euthanasia as "cases involving intentional killing" (p. 244). The debate over the active/passive distinction is not likely to achieve quick resolution. Given a current lack of consensus, this investigator will accept Weir's notion of treatment abatement as passive euthanasia, and euthanasia as intentional killing.

Despite ambiguities in the use of the term euthanasia, there is general agreement in the philosophical literature that the individual has an autonomous right to death with dignity (Abrams, 1978; Engelhardt, 1975/1982b; Fletcher, 1974; Kohl, 1978; Rachels, 1975/1982; Veatch, 1977/1982; Williams, G., 1958/1982; Williams, P., 1977/1978). That agreement is, however, tempered with concerns that euthanasia may become a 'slippery slope' for morally reprehensible acts, such as pressuring the sick and elderly to end

their burden on society (Beauchamp, 1978/1982c; Beauchamp & Childress, 1979/1986; Childress, 1978; Kamisar, 1958/1982; Singer, 1979/1986).

Treatment Abatement. As was discussed earlier, treatment abatement can be considered to be synonymous with passive euthanasia. Treatment abatement for critically ill patients hinges on what is considered to be the distinction between ordinary or extraordinary treatment. Also influenced by the Quinlan case, the ordinary/extraordinary treatment distinction:

is that patients have a legal right to expect ordinary care, and arguably may have a duty to accept it, but that administration of extraordinary care is legally discretionary on the part of patients, legal guardians of incompetent patients, and physicians. Further, since there is no legal duty to initiate extraordinary care, there is no duty to maintain it if such care is undertaken (Dickens, 1984, pp. 198-199).

The Law Reform Commission of Canada (1982) has emphatically stated that the physician is under no obligation to deliver extraordinary treatment, and that the incompetent patient's right not to undergo extraordinary treatment must be protected.

However, "the words 'ordinary' and 'extraordinary'

are fraught with vagueness and ambiguity" (Bandman & Bandman, 1985, p. 248). Cassell (1986) warns that critical care units have become a self-perpetuating technology for resuscitation and maintenance of cardiopulmonary and renal function. Hence, what is considered ordinary in the context of a critical care unit may be very different from what is considered ordinary on a general medical ward. The ordinary/extraordinary distinction is thus dependent on current medical practices, and may be inconsistent even within the same institution.

Confounding this inconsistency is the relative lack of Canadian case law in the area (Law Reform Commission of Canada, 1982). One case that comes close to illustrating the issue of treatment abatement in Canada is that of Stephen Dawson (re Dawson, 1983). In this case, Mr. Justice L. McKenzie overturned a previous decision by a provincial court judge, ruling that the parents of a severely handicapped child with hydrocephalus could not refuse surgery for a shunt revision. Despite the agreement of the family physician, the neurosurgeon, an independent family physician, and the parents, Mr. Justice L. McKenzie made the decision that the court should determine what was best for the child (Kluge, 1983). This Supreme

Court ruling, although based on different factual evidence than that of the Provincial Court, has been criticized because it ignores the situational context of determining ordinary from extraordinary measures, and because it violates the incompetent person's right for proxy decision-making (Dickens, 1984; Kluge, 1983). Until subsequent cases arise, it would appear that we are left with even less direction to determine what ordinary treatment is and to respect the autonomy of incompetent patients to make choices in their treatment.

The one facet of treatment abatement that has received some clarification in the ethical and legal arenas has been resuscitation. There is general agreement in the literature that withdrawal of resuscitation can be an ethically and legally sanctioned decision (Alspach, 1985; Cassell, 1986; Gordon & Hurowitz, 1984; Kellmer, 1986; Miya, 1984; Rozovsky & Rozovsky, 1985; Yarling & McElmurray, 1983). Within Canada, the Canadian Hospital Association [C.H.A.], the Canadian Medical Association [C.M.A.], and the Canadian Nurses' Association [C.N.A.], have provided guidelines for such a decision in the form of a Joint Statement on Terminal Illness (1984). As a result of this clarification, it is

becoming more established that physicians may write 'no code' orders for patients experiencing prolongation of the process of dying. However, other treatment measures such as ventilation and hemodynamic monitoring may well continue. Given patients who do not meet the biomedical criteria of dead or dying, uncertain mechanisms for incompetent patients to refuse treatment, and vague and inconsistent notions of what constitutes ordinary or extraordinary treatment, this is not surprising.

It should also be noted that even given the clarification in the nursing, medical, ethical, and legal literature, the implementation of withdrawal of resuscitation itself is not without problems. The Joint Statement on Terminal Illness (C.H.A., C.M.A., C.N.A., 1984) makes it clear that a 'do not resuscitate' order must involve informed consent of the patient or proxy. This is frequently not the case (Alspach, 1985; Cassell, 1986; Evans & Brody, 1985; Yarling & McElmurry, 1983). Furthermore, institutional policies and procedures for 'do not resuscitate' orders are often incomplete (Alspach; Evans & Brody; Yarling & McElmurry).

Death With Dignity. Before closing this review of ethical issues related to prolongation of the process

of dying, it will be important to focus on the notion of death with dignity. Death with dignity is inherent in the previous discussions of euthanasia and treatment abatement, and implies maintaining respect for dying individuals' personhood. Personhood has been described as incorporating the notion of individuals as self-conscious, rational moral agents (Engelhardt, 1982a). Within nursing, the implications of respect for personhood have been articulated in terms of fostering self-determination (Gadow, 1980/1983). This mandates respect for "the individual's own decision about the meaning which an experience contains, before decisions are reached about responding practically to the experience" (Gadow, p. 55).

Death with dignity, therefore, implies that individuals have the right to make sense of and choices in their own dying process. Even lacking the competence necessary for the above, death with dignity implies that the people have the right to be valued and respected and to make choices by proxy (Englehardt, 1982a).

A corollary of death with dignity is that the person experiencing the dying process should be afforded some quality of life while dying (Fletcher, 1974). This is indicated in the use of the term

euthanasia, which "comes from the Greek, meaning good or pleasant death" (Davis & Aroskar, 1983, p. 140). A major focus in discussions of quality of life in dying therefore centers around relief of suffering (Dyck, 1975/1986). Suffering can be defined not only as pain, but "as the state of severe distress associated with events that threaten the intactness or wholeness of the person" (Cassell, 1983, p. 522).

Summary of Related Ethical Issues. The literature review on Related Ethical Issues has attempted to present the ethical issues within which prolongation of dying is embedded so that ethically relevant threads of complex situations can be drawn out. A summary of these ethically relevant threads reads as follows:

1. The current adoption of purely biomedical criteria to determine death leaves us with an incomplete understanding of what it means to call a person dead or dying.

2. Euthanasia can be considered on a continuum ranging from treatment abatement to intentional killing. Within the context of euthanasia, there is general agreement that the individual has a right to death with dignity, but this agreement is tempered with concerns about potential abuse.

3. There exists an uncertain mechanism for

incompetent patients in critical care to exercise their autonomous right to refuse treatment.

4. Although there is no legal obligation for physicians to pursue extraordinary treatment for competent or incompetent patients, the definition of extraordinary is vague and inconsistent.

5. There is general agreement that withdrawal of resuscitation can be an ethically and legally sanctioned decision in prolongation of dying, but the implementation of withdrawal of resuscitation may be inconsistent.

6. Death with dignity is a notion implicit in euthanasia and treatment abatement, and implies that individuals have the right to make sense of and choices in their own dying process.

7. Relief of suffering is a major focus in the notion of death with dignity.

Related Ethical Research

As was stated in Chapter One, there is little written that actually explores ethical situations faced by nurses with their dying patients (Crisham, 1981; Davis, A., 1981; Davis & Aroskar, 1983; Omery, 1983b). This section of the literature review will explore the research on ethical issues within nursing that does exist, and will examine the implications for our

understanding of nurses' ethical perspectives on prolongation of the process of dying. The focus in this section will be on descriptions of nurses' experiences in ethical issues, while the next section of Chapter Two will focus on nurses' moral reasoning in ethical situations.

Related Ethical Research will be approached first by examining early studies of the ethics of nursing practice; secondly, by examining studies of the ethics of resuscitation; and finally, by examining recent studies of nurses' ethical perspectives.

Early Studies. Concern about the ethics of nursing practice is a relatively recent phenomenon. One of the first studies to appear in the literature was published by Nursing '74 (1974a & b). In this study, 11,000 readers of the journal from the U.S. and Canada responded to a 73-item closed-response questionnaire, many nurses supplementing the questionnaire with written anecdotes (Nursing '74, 1974a, p. 35). The anecdotes were described as being "read by [the] editors with a growing sense of fascination" (Nursing '74, 1974a, p. 35).

The survey covered many of the ethical facets of nursing practice. In general, the results of the survey portrayed "a positive image of today's nurse as

a confident professional still plagued by doctors' expectations of subservience . . . frustrated by inability to intervene in the patients' behalf . . . and concerned about difficulty in maintaining nonjudgemental attitude [sic] toward certain patients" (Nursing '74, 1974a, p. 44).

More specifically in terms of this thesis, nurses expressed difficulty in discussing death with patients, or intervening when the physicians had not informed patients of their condition (Nursing '74, 1974b, p. 62). Citing one anecdote, the editors reported that "[one] nurse saw the ethical problem as a 'lack of concern for the quality of life evident in treatment of chronic or terminally ill persons'" (Nursing '74, 1974b, p. 62). Responding to a question of whether or not a nurse should "call a code for an unexpected cardiac arrest in a terminally ill patient when the doctor has left no instructions", 54% of the respondents replied no (Nursing '74, 1974b, p. 62). The editors offered an interpretation of the responses to this question by stating that "half of the nurses would allow the patient the dignity of a natural death and perhaps death without prolongation of pain and suffering" (Nursing '74, 1974b, p. 62). A second anecdote was illustrated from a nurse who worked in

ICU, expressing concern about "prolonging life by artificial means" (Nursing '74, 1974b, p. 62).

Religious background was not found to have made a difference in this area, with less education correlating with more likelihood that the nurse would call a code for a terminally ill patient (Nursing '74, 1974b, pp. 62-63).

Two other findings of the survey are noteworthy. One finding that was expressed a few times was nurses' expressions that they felt the survey was necessary and that they had never had the opportunity to respond to or make disclosures on ethical issues (Nursing '74, 1974a). Secondly, in the area of challenging a physician's incorrect order, the editors postulated that their findings reflected a "difference between what nurses **say** they would do and what they actually **do** in practice" (Nursing '74, 1974a, p. 39).

The same year that Nursing '74 (1974a & b) undertook its survey, the Canadian Nurses' Association [C.N.A.] Special Committee on Nursing Research "became increasingly aware of the changing nature of nursing practice and of the potential ethical and moral problems confronting practitioners" (Allen, 1974, p. 22). Sending out several requests in the Canadian Nurse for nurses "who had faced a particular ethical

problem to describe the situation in detail", only 22 responses were received (Allen, p. 22). Allen's analysis of the examples received was as follows:

. . . it would appear, in many instances, that the problem of responding to the individual patient and of meeting his needs was perceived to be in conflict with directives arising from other sources - medicine, hospital policy, the law, or religion. Other ethical considerations dealt with how to cope or how to respond in highly complex, multi-problem situations (Allen, p. 23).

Allen (1974) specifically noted that no problem was cited that dealt with "the problem of life and death, such as maintaining life for long periods in non-responding individuals" or "euthanasia" (p. 23). Allen concluded that "it would appear that nurses seldom experience ethical problems", and that their problems lay in determining to whom the nurse was responsible, and "to get other people to behave in [the nurse's] ethical fashion" (p. 23).

It is difficult to take a great deal of direction from Allen's (1974) report. First, she did not comment on why the response rate might have been so small. Secondly, her use of the term 'ethical problem' is confusing. Nurses experienced situations in which

their care of patients was in conflict with directives arising from other sources, yet Allen did not define this as an ethical problem. Perhaps what is most noteworthy in Allen's report is that the C.N.A. Committee on Nursing Research was concerned about potential ethical and moral problems confronting nursing practitioners.

Another early study relating to the ethics of nursing practice was published from the department of psychology at Teacher's College, Columbia University in 1975 (Davitz & Davitz, 1975). Davitz & Davitz employed small group interviews with over 200 nurses to address the following:

While much attention has focused on patients' reactions to pain and illness, what about the nurse? What happens to nurses' judgements, emotional reactions, and personal attitudes in a profession that demands daily encounter with pain and distress? How do nurses feel about their experiences? (p. 1505).

Although Davitz and Davitz approached the question from a psychological standpoint, the emphasis on nurses' judgements and attitudes and patient suffering fits within the scope of ethical considerations.

Davitz and Davitz's (1975) findings emphasized "the

nurse's sense of being overwhelmed by the very real suffering of patients she works with every day" (p. 1508). Nurses described particular difficulty responding to the psychological aspects of suffering. Davitz and Davitz further identified nurses' early attitudes of idealism being 'jolted' by the realities of practice, and their experiences of overinvolvement with patients leading to the development of a degree of emotional distance. The findings of the study emphasized nurses' responses in terms of processes evolving over time.

Of particular importance is Davitz and Davitz's (1975) conclusion that "reactions to the death and dying of patients clearly elicited the strongest emotional responses" (p. 1510). Although prolongation of the process of dying per se was not identified as an area of concern, Davitz and Davitz's conclusion is noteworthy. "Perhaps the only conclusion that needs to be drawn is a reaffirmation of the necessity to continue, and even expand, our concern for those who face the fact of mortality in their everyday professional lives" (p. 1510).

In review of the early studies of the ethics of nursing practice, then, we find a large survey indicating that nurses feel frustrated by their

inability to intervene in the patient's behalf, and feel concerned about prolonging life with artificial means. A second survey identifies nurses as experiencing situations in which their care of patients is in conflict with other sources. A third study emphasizes the emotional costs experienced by nurses working with patients who are suffering, particularly those patients who are dying. Interestingly, the emphasis from these studies on situational constraints perceived by nurses is similar to that found in the early critical care nursing stress literature (Cassem & Hackett, 1975; Gentry, Foster & Froehling, 1972/1982; Hay & Oken, 1972/1982; Menzies, 1960/1982; Vreeland & Ellis, 1969/1982). Furthermore, Davitz and Davitz's (1975) description of nurses' idealism being jolted by the realities of practice is similar to Kramer's (1974) notion of reality shock, and Storlie's (1979/1982) notion of burnout. It would appear that what we begin to see in the ethical and stress literature are fundamentally the same concerns being approached from different theoretical perspectives.

In relation to the similarity of concerns arising in the ethical and stress literature over time, it is apparent that situational constraints of high workloads, interpersonal conflicts, and lack of

physician and administrative support have been consistently identified as sources of stress for critical care nurses (Bailey, Steffen & Grout, 1980; Cassem & Hackett, 1975; Gentry, Foster & Froehling, 1972/1982; Hay & Oken, 1972/1982; Jacobson, 1979/1982; Oskins, 1979/1982; Vreeland & Ellis, 1969/1982). As a consequence of prolonged exposure to the negative conditions in their situation and lack of exposure to the positive conditions of patients getting better, critical care nurses are seen to suffer burnout and leave (Alexander & Chase, 1982; Consolvo, 1979/1982; Dear, Weisman, Alexander & Chase, 1982; Holsclaw, 1965; Millar, 1980; Pines & Kanner, 1982; Stone, Jebson, Walk & Belsham, 1984; Vreeland & Ellis, 1969/1982; White, 1980/1982). Burnout and attrition have thus come to be viewed as responses by nurses to the prolonged exposure to negative conditions in their situation and lack of positive conditions of patients getting better. Implicitly, then, burnout and attrition have come to be viewed as nurses' responses to ethical problems such as prolongation of the process of dying. What is not clear from the literature is what other kinds of responses nurses may make to ethical problems such as prolongation of the process of dying.

Studies on Resuscitation. Studies on the

resuscitation of critically ill patients have become more frequent in the recent literature, and illustrate ethical as well as biomedical concerns. A nurse researcher, Witte (1984), undertook a retrospective chart review of patients who had been resuscitated to determine "which of a set of specific demographic, physiologic and psychosocial variables were present when intensive care patients were to be resuscitated" (p. 159). Witte found that "duration of hospitalization, the level of consciousness, and the presence of documentation of wishes of family or significant others" correlated with 'do not resuscitate' orders (p. 161). Witte expressed approval that considerations such as quality of life and proxy decision-making were significant in decisions to withdraw resuscitation. Witte concluded her study by stating that the "issue of resuscitation involves every health care provider concerned about ethical decision making in the best interests of critically ill patients" (p. 163). Given the presence of "little data . . . to help clarify the process", Witte called for further research (p. 163). The call for biomedical data to clarify decision-making in resuscitation has been echoed by Cassell (1986).

Berseth, Kenny, and Durand (1984), two physicians

and an investigator from a graduate school of public affairs, set out to "discern the attitudes of nursing personnel in intensive care and intermediate care nurseries toward high-risk infants and their parents, and to examine certain factors that may influence those attitudes" (p. 508). A closed-response questionnaire was administered in 1979 to nurses working in the two different kinds of nurseries in two different agencies (Berseth et al., p. 508). The findings indicated that nurses working in intensive care nurseries and nurses who had longer work experience in intermediate care nurseries were less likely to "favour resuscitation of certain high-risk infants" (Berseth et al., p. 510). A large proportion of both groups of nurses felt that "a child whose death [was] imminent but who [did] not require extensive hospital support should be cared for at home" (Berseth et al., p. 510).

Berseth et al. (1984) interpreted intensive care nursery nurses' responses as indicating that "ICU nurses rarely have the positive reinforcement of observing the recuperation or dismissal of the patients who survive" (p. 510). No mention was made of nurses' notions of quality of life or relief of suffering in relation to their findings, even though "ICU nurses also were more likely to agree with the concept of

active euthanasia" (Berseth et al., p. 110). It is difficult to interpret Berseth et al.'s explanation of why nurses who had longer work experience in the intermediate care nursery were less likely to favour resuscitation. Berseth et al. made the statement that "a nurse's selection of an [intermediate care nursery] assignment could represent an attempt to avoid the potential grief and anxiety of caring for dying patients in the ICU" (p. 110). Furthermore, Berseth et al. concluded that their finding that both groups of nurses would prefer to see a dying child cared for at home "may indicate the stress that nurses feel in caring for dying patients and their families" and "may be at least partially a reflection of guilt feelings that less-than-perfect service has been provided" (p. 110).

This investigator is distressed to find non-nurses obliquely interpreting nurses' attitudes. Nurses' perceptions of why they chose the responses they did were never explored, and it is difficult to follow the direction Bersham et al. (1984) took from the literature in their interpretations.

A third study on the resuscitation of critically ill patients was undertaken by Lewandowski, Daly, McClish, Juknialis, and Youngner (1985). Two of the

investigators were nurses. Given a "need to determine which treatments are appropriate for a patient who is not to be resuscitated" (p. 175), Lewandowski et al. addressed the following questions:

- (1) What levels of medical and nursing resources do ['do not resuscitate'] patients consume in the ICU?
- (2) What impact does the ['do not resuscitate'] order have on the withdrawal or initiation of certain life-sustaining and nursing interventions?
- (3) Do ['do not resuscitate'] patients survive the ICU and hospital? (p. 175).

Data for the study were obtained from a large prospective study, and were analyzed in terms of demographic and clinical characteristics, resource consumption, and nursing care requirements (Lewandowski et al., 1985).

The findings indicated the following: (a) It was not uncommon for 'do not resuscitate' patients to occupy beds in a medical ICU. Two patients during the course of the study were admitted with 'do not resuscitate' orders. The investigators concluded that patients who were not candidates for resuscitation were considered candidates for intensive care; (b) The 'do not resuscitate' order had a limited influence on the withdrawal of specific aggressive therapies such as

ventilation and hemodynamic monitoring. The investigators interpreted this finding as indicative of the ethical issues involved, and as indicative of physicians' uncertainty about the legal implications of euthanasia and treatment abatement; (c) 'Do not resuscitate' patients continued to demand a high level of nursing care. The investigators noted that nursing staff may have underestimated the levels of psychosocial support required by these patients and their families; (d) Despite aggressive treatment, hospital mortality rates for 'do not resuscitate' patients were extremely high (Lewandowski et al., 1985, pp. 179-181).

Lewandowski et al. (1985) concluded by expressing concern that aggressive medical treatment for 'do not resuscitate' patients conflicted with the reality of patients with a poor quality of life, wasted scarce ICU resources, and caused "undue patient suffering" and "crippling financial burdens" (p. 181). The investigators called for further studies to justify resuscitation and subsequent care and treatment decisions as well as to determine the quality of life of 'do not resuscitate' patients who survive hospitalization.

The studies reviewed on the resuscitation of

critically ill patients illustrate that considerations such as quality of life and proxy decision-making may be taken into account, but that treatment abatement in terms of resuscitation may take place without withdrawal of other technological interventions. Resuscitation decisions appear to be of concern to nurses, and the care of patients designated as 'do not resuscitate' absorbs significant nursing resources in the ICU. Further research has been called for to justify resuscitation decisions as well as subsequent care and treatment decisions in terms of quality of life.

Recent Studies. Recent studies on nursing ethics have started to focus more purposefully on nurses' ethical perceptions. A. Davis (1981) expressed concern about the lack of qualitative data on ethical issues faced by nurses. In particular, she expressed concern about the historical preponderance of closed-response questionnaires:

Predetermined categories that limit the nature of the question as well as the possible responses act to define reality according to the researchers' perception not according to the experience of those being studied. As useful as such data from a questionnaire may be, they reflect what the

researchers believe to be the pressing issues and may or may not fit with the complexities of the actual nursing experience (Davis, A., p. 398).

In response to her own concerns, A. Davis (1981) administered a survey in open-ended format to 205 nurses "so that the participants could indicate those ethical dilemmas that were particularly troublesome to them" (p. 398). More specifically, the survey focused on "(1) the extent to which nurses understand the concept, ethical dilemma, (2) the content of the ethical dilemmas that confront nurses, and (3) the relationships among ethical dilemma variables and selected employment and demographic variables" (Davis, p. 397). It should be noted that A. Davis' use of the term 'ethical dilemma' is congruent with the term 'ethical problem' as used in this thesis.

A. Davis' (1981) findings were that the majority of respondents to her survey were "young staff nurses who had a good grasp of the concept, ethical dilemma" (p. 404). Importantly, one of the most frequently occurring dilemmas was "prolonging life with heroic measures" (Davis, A., p. 404). It is relevant to note that the identification of prolongation of the process of dying as a specific concern of nurses has been paralleled in some of the research on critical care

nursing stress (Bailey, Steffen & Grout, 1980; Cassem & Hackett, 1975; Jacobson, 1982/1979; Steffen, 1980).

A. Davis (1981) also found that younger nurses were "more apt to experience difficulties around ethical dilemmas with patients, families, physicians and institutions than were older nurses" (p. 404). The emphasis from A. Davis' study on nurses' difficulties with physicians and institutions supports the emphasis on situational constraints noted earlier in the stress literature. A. Davis also posited that the difficulties experienced by younger nurses reflected "the idealism of youth" (p. 404). This notion parallels Kramer's (1974) description of reality shock, where postgraduate nurses' socialization results in conflict between educational and workplace ideologies. Perhaps nurses newer to the profession experience the conflict in a different manner than nurses with more longevity. The study reviewed earlier in this chapter by Davitz and Davitz (1975) emphasizes nurses' responses to patient suffering as processes evolving over time. Nurses' responses as evolving over time is emphasized again in A. Davis' study when she noted that diploma nurses "indicated that they disagreed more often with physicians", possibly because as a group the diploma nurses had worked longer (p. 404).

A final point in review of A. Davis' (1981) study was her statement that nurses were in need of dialogue on ethical issues, and wrote "numerous and often lengthy" comments on the back of the survey forms to that effect (p. 405). A. Davis concluded by stating that "such comments ranged from thanking the researcher for the opportunity to participate in a study on an important and increasingly troublesome topic to bitter comments as to why individuals considered leaving nursing as the only ethical option open to them" (p. 405). The comments described by A. Davis are reminiscent of the comments purportedly read by the editors in the Nursing '74 (1974a) study with "a growing sense of fascination" (p. 35). In both studies, as well as in a study to be reviewed later by Crisham (1981), nurses emphatically indicated that they needed an opportunity to express themselves on ethical concerns.

A second study illustrating facets of nurses' ethical perceptions was undertaken by a sociologist in Great Britain (Field, 1984). Field examined "nurses' accounts of their experiences of nursing dying patients and their attitudes towards nursing the dying" (p. 59). Field's study is particularly relevant to the literature reviewed in this thesis in terms of nurses'

perceptions of situational constraints because Field emphasized "ways in which the organization of [nurses'] work influences [their] experiences and attitudes" (p. 59). This emphasis is congruent with other sociological studies examining the social contexts of health care, or "the ways in which the social organization of health-care institutions affects health-care practices and outcomes" (Mishler, 1981). Other sociological studies that establish the importance of understanding the social organization of the hospital in order to understand institutional practices vis-a-vis dying patients include those by Glaser and Strauss (1965) and Sudnow (1967).

Field (1984) undertook informal audiotaped interviews with the nursing staff of a general medical ward. He found that nurses preferred open disclosure with patients who were dying, and that emotional involvement was "inevitable and unavoidable" (Field, p. 64). Nurses' preferences for open disclosure is reminiscent of nurses' difficulty intervening when physicians had not informed patients of their condition reported in the Nursing '74 (1974a & b) survey. Field's findings in terms of emotional involvement reflect those of Davitz and Davitz (1975).

A study that focused specifically upon critical

care nurses' ethical perceptions was recently undertaken by a nurse researcher, Fenton (1987).

Fenton focused on the following research questions:

1. What are the ethical dilemmas that critical care nursing students and their instructors perceive in clinical practice?
2. What are the feelings, attitudes and beliefs that critical care nursing students and their instructors have in relation to these ethical dilemmas?
3. How do critical care nursing students and their instructors come to terms with these ethical dilemmas? (pp. 6-7).

Interestingly, Fenton's questions reflect a concurrent focus on perceptions and coping that is becoming more apparent in the stress literature (Monat & Lazarus, 1985). Fenton selected a phenomenological approach to address her research questions, and conducted interviews with five critical care nursing students and five critical care nursing instructors. Fenton chose the two groups in order to obtain data from nurses inexperienced in critical care as well as nurses with extensive experience in critical care.

Fenton (1987) summarized her findings in terms of "the situational context of an ethical dilemma, factors

influencing individual response to the situation and finally the manner of response and coping with an ethical dilemma" (p. 198). Within the situational context of an ethical dilemma, a major theme was excessive therapy, four elements of which were "loss of patient dignity, patient comfort, violation of patient's rights or wishes and family suffering" (p. 199). Fenton's identification of the major theme of excessive therapy thus makes more explicit nurses' ethical perceptions in terms of prolongation of the process of dying.

Two other themes included the interpersonal dimension and discontinuation of therapy (Fenton, 1987). The interpersonal dimension included nurses' concerns about poorly informed patients and conflicting professional loyalties. In terms of discontinuation of therapy, some nurses felt concerned about their role as caregivers and about the manner in which decisions were made in relation to discontinuation of therapy. These concerns support the premise of this thesis that we cannot assume what individual nurse's ethical perspectives will be in relation to prolongation of the process of dying. In other words, some nurses may view discontinuation of therapy as a more significant problem than excessive therapy. Fenton's thesis

provides further support for the importance of disclosure to patients and families and situational constraints in nurses' perceptions of ethical problems.

Fenton (1987) concludes her study with the concern that "the experience of these kinds of patient care situations may be the source of significant personal distress for the nurse who becomes involved with the patient and family in crisis" (p. 220). Fenton's study thus supports Field (1984) and Davitz and Davitz (1975) in terms of illustrating the emotional involvement of nurses' experiences with dying patients.

To summarize the recent research on nurses' ethical perceptions, we find prolongation of the process of dying emerging as a central ethical problem. Prolongation of the process of dying has become increasingly clarified in terms of nurses' concerns about lack of disclosure with patients and families, loss of patient dignity, loss of patient comfort, violation of patient's rights or wishes and family suffering. Nurses' perceptions of prolongation of the process of dying are embedded in the context of situational constraints such as conflicts with physicians and lack of administrative support. Nurses' responses appear to evolve over time, and incur significant emotional involvement.

Nurses' responses to their perceptions necessitate some decision-making in ethical situations. Therefore, the next section of Chapter Two will provide the basis to explore nurses' responses in terms of their decision-making in ethical situations.

Moral Reasoning

Introduction

To cite Fletcher (1974), the "crucial business of ethics is decision making, not the adumbration of abstract principles" (p. 14). Implicit in the definition of an ethical problem is the necessity to make a decision (Curtin, 1981a). The review of the literature to this point has illustrated nurses' perceptions of prolongation of the process of dying as an ethical problem. What we have not examined is how nurses are believed to make decisions in the context of the ethical problem of prolongation of the process of dying.

Making decisions in the context of an ethical problem involves a process known as moral reasoning. That process is based on the individual's moral development. This section of Chapter Two will commence by examining some theories of moral development, and will then examine the application of these theories in nursing research on moral reasoning. The investigator

will conclude by reaffirming the conceptualization of the problem statement in Chapter One.

Theories of Moral Development

The review of theories of moral development within this Chapter will take direction from Omery. To begin, Omery states that moral development can be defined as:

the process of internalizing suggestions or action guides that are obligatory (impersonal, unalterable, or ahistoric), generalizable, and important. These action guides are, furthermore, based on ethical principles such as justice or utility and are used in a specific type of situation (Omery, 1983b, p. 3).

Omery identifies three major classifications of models of moral development as including psychoanalytic, cognitive-developmental, and social learning models.

Psychoanalytic models look at moral development in terms of the development of the superego, although the use of these models is not apparent in the nursing literature (Omery, 1983b). The social learning models look at societal influences on learned social behavior (Omery, p. 6). These models are more apparent in the educational literature, particularly as theorized by Bandura (1971). Bandura views moral development in terms of persons acquiring given behaviors and then

applying those behaviors in future situations through a process of insightful expectations and goal setting and attainment (Bigge, 1982, p. 157). Bandura's theory of moral development emphasizes "reciprocal interaction" between persons and their environments in the learning of moral behavior (Bigge, p. 158)

Cognitive-developmental models have been widely applied in both educational and nursing literature. These models view moral development in terms of "the conversion of certain inherent and primitive attitudes and conceptions into a comprehensive set of internal moral standards" (Omery, 1983b, pp. 4-5). The process of internalization is described as an invariant sequence of stages paralleling the person's cognitive development (Ketefian, 1981a; Omery).

The most widely applied cognitive-developmental model has been that of Kohlberg (Omery, 1983b). Kohlberg's model of moral development (1972; 1981) set an important historical precedent in the cognitive-developmental models because it was the first "to embrace philosophy as essential to defining what is moral as the first required step in the study of moral development" (Lickona, 1976, p. 4). Lickona goes on to explain that "[m]oral philosophy is thus used to define the endpoint of moral development as being justice, and

to provide the moral concepts . . . to analyze **observed** developmental progress toward the highest form of justice . . ." (p. 5). As was cited in Chapter One of this thesis, Kohlberg (1972) identifies the final stage of development towards the highest form of justice as "[m]orality of individual principles of conscience that have logical comprehensiveness and universality. Highest value [sic] placed on human life, equality, and dignity" (p. 15).

In critique of Kohlberg (1972), Gilligan (1977) posits a different hierarchy to address womens' morality of responsibility. Gilligan proposes universal care as the highest obligation in her hierarchy of moral development (Omery, 1983b). Returning again to Chapter One of this thesis, it should be noted that Sullivan's (1977) concerns about Kohlberg's hierarchy do not appear to have been addressed in a subsequent cognitive developmental model. Thus we are left with a hierarchy that fails to distinguish thought from action, form from content, the abstract from the concrete or the emotional from the intellectual (Sullivan, p. 15).

It would appear, then, that the cognitive developmental models of moral reasoning give us direction to look at the implementation of the

principle of justice, and to look at themes of responsibility and care for women. We are left with little direction in terms of men's reasoning vis-a-vis responsibility and care. With both sexes we lack direction to understand moral action, moral content, concrete information and feelings in terms of moral reasoning. These latter facets are likely prerequisite to understanding the situational context of moral reasoning. Given the emphasis throughout this literature review on situational constraints as perceived by nurses, this leaves us with limited benefits in applying current cognitive-developmental theories of moral development to nurses' ethical perspectives on prolongation of the process of dying.

Nursing Research on Moral Reasoning

The purpose of this section of Chapter Two is to examine the application of moral development models within nursing research. The thrust within nursing research is to look at moral development as it is evidenced by the process of moral reasoning. For the purposes of this thesis, moral reasoning will be defined as the process of implementing moral action guides to make decisions in ethical situations (Omery, 1983b).

Application of Kohlberg's Model. Given the current

theoretical emphasis on Kohlberg (1972; 1981), most nursing research on moral reasoning takes direction from Kohlberg's cognitive-developmental model.

An early study appearing in the nursing literature that gives evidence of the application of Kohlberg's (1972; 1981) model was a doctoral dissertation by Schoenrock (1978/1979). In this study, participants completed questionnaires, the results of which indicated that there was "not a significant number of nurse participants" at Kohlberg's higher stages of moral reasoning (Schoenrock, p. 4035-A). "A major conclusion was that there existed a need to revise or develop moral content in the baccalaureate nursing curriculum . . . to include more teaching strategies designed to promote moral reasoning levels in professional nurses" (Schoenrock, p. 4035-A). This conclusion has been echoed by several other nurse-educators (Clay, Povey & Clift, 1983; Johnston, 1980; Munhall, 1982; Reilly & Oermann, 1985; Schrock, 1980; Vito, 1983).

Crisham (1981) however, identified a lack of understanding in the literature about "the relationship of moral judgement development to decision making in the practice of nursing", and investigated the "difference between nurses' responses to general,

hypothetical moral dilemmas and their responses to real-life nursing dilemmas" (p. 104). Working from Kohlberg's cognitive-developmental theory, Crisham developed a nursing dilemma test to identify "21 recurrent nursing moral dilemmas" from 130 staff nurse interviews (p. 106). More than 200 nurses of varying educational levels were then asked to complete a nursing dilemma test and a general hypothetical defining issues test (Crisham).

Crisham's (1981) results indicated that an increasing level of education was related to a higher level of moral judgement about hypothetical general issues, and that moral judgement about real-life nursing dilemmas as defined in the nursing dilemma test was only partially explained by level of education (p. 110). Crisham also noted that "more experienced staff nurses did not have higher moral judgement scores . . . but gave significantly greater importance to practical considerations" (p. 110). Crisham postulated that staff nurses "interpreted the dilemmas in terms of the distractions and pressures within the hospital milieu" (p. 110). Crisham concluded by calling for elaboration of the situational context of nurses' moral reasoning. She stated that to "advance knowledge of moral judgement, it is necessary to clarify situational

pressures, conflicting claims, and contexts of professional dilemmas, and to investigate the interaction of these milieu effects with the practitioner's concepts of fairness" (p. 110).

Another nurse researcher, Ketefian (1981a; 1981b; 1985), has been widely cited for her studies of moral reasoning utilizing Kohlberg's (1972; 1981) model. The first study by Ketefian (1981a) examined whether there was a "relationship between critical thinking, educational preparation, and levels of moral reasoning among selected groups of nurses" (p. 98). A large group of practicing nurses completed a packet of tests, the results of which indicated that "the higher the nurses' critical thinking, the higher their moral reasoning was likely to be", and that "nurses who had professional education had more advanced levels of moral reasoning than those who had received technical nursing preparation" (Ketefian, 1981a, p. 102). It should be noted that the tests employed by Ketefian (1981a) were closed-response and hypothetically based. Ketefian (1981a) pointed out that her study was "a beginning step" and that any "implications drawn need[ed] to be viewed cautiously and tentatively" (p. 102).

Ketefian's second study (1981b) addressed the

question of whether "there is a relationship between moral reasoning and knowledge and valuation of ideal moral behavior in nursing dilemmas" and whether "there [is] a relationship between moral reasoning and nurses' perception of realistic moral behavior in nursing dilemmas" (p. 171). Citing the importance of "[s]ocial and educational climates" in moral development, Ketefian went on to postulate that there may be a difference between the thought processes of a moral choice and the "nature of the moral act itself" (p. 172). The same sample of nurses from the first study completed a test containing seven stories depicting nurses in hypothetical ethical dilemmas (Ketefian). Respondents chose whether or not the nurse in the study **should** engage in a selection of nursing actions and whether or not respondents thought the nurse in the story was **likely** to engage in a selection of nursing actions (Ketefian, p. 173). Professionally prepared nurses demonstrated higher levels of moral reasoning in terms of what **should** be done, however there was no significant difference between what professionally and technically prepared nurses thought was **likely** to happen (Ketefian, p. 175). Ketefian pointed out that "the validity of any inferences from such an assessment to what the respondent herself might actually do are

open to question" (p. 175). Ketefian went on to express concern that "nurses' knowledge and values do not seem to be translated to reality" (p. 175) and speculated that this may be because:

large bureaucracies . . . might unwittingly be forcing new and young graduates to change their professional orientations to endorse values of the organization; these nurses may be facing the choice of making such a change in their values or leaving the setting or nursing" (p. 175).

What we start to see in Crisham's (1981) and Ketefian's (1981b) studies is evidence that moral reasoning in nursing cannot be viewed outside of a situational context. By distinguishing moral choice from moral action, Ketefian uncovered important dimensions of nurses' moral reasoning. Her concerns parallel those found in the stress and burnout literature in terms of the impact of the situational context on nursing practice.

The latest study by Ketefian (1985) expanded on the situational context in terms of moral behavior. Ketefian "examined the relationship between role conceptions and role discrepancies and moral behavior as a selected dimension of professional practice" (p. 248). Moral behavior was chosen as an index of

professional behavior (Ketefian, 1985). Using a sample of 217 registered nurses, Ketefian (1985) administered the same test containing stories of nurses in hypothetical dilemmas as in her previous (1981b) study. A nursing role conception measure was also administered (Ketefian, 1985). Ketefian's (1985) findings indicated that strong professional role conceptions were related to higher hypothetical moral behavior, and that "educational experience to a large extent shap[ed] nurses' role orientation" (p. 253). High professional role conflict resulted in lower hypothetical moral behavior, while high professional role orientation accompanied by high bureaucratic orientation resulted in less role conflict (Ketefian, 1985, p. 253). Ketefian (1985) concluded by stating that it "is evident that professional role conflict has an adverse effect on moral behavior; effort needs to be directed toward reducing such conflict and closing the gap between beliefs held and perceived reality" (p. 253).

Following Crisham's (1981) and Ketefian's (1981a; 1981b) work, R. Lamb (1985) undertook a nursing study that was founded on Kohlberg's (1972; 1981) cognitive-developmental model of moral reasoning but focused on the contextual nature of nurses' moral

reasoning. R. Lamb introduced the intent of her study as follows:

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 (p. 8).

More specifically, R. Lamb posed her research question as: "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" (p. 4).

R. Lamb (1985) employed a qualitative, grounded theory methodology to conduct semi-structured, in-depth interviews with eleven nurses of varying backgrounds. R. Lamb's analysis "incorporated a continual referral

to and assessment of patterns of reasoning as detailed in cognitive moral development theory", and sought "core concepts . . . from within the data . . . that would provide a view to the nurse's subjective experience at the time" (p. 31). Situations described by R. Lamb's respondents that involved "conflict of loyalty situations with their beliefs about patient autonomy" included: "(a) intrapersonal conflicts with personal-professional ambivalence . . . ; (b) intraprofessional difficulties between nurses . . . ; (c) interprofessional problems with physicians and social workers . . . ; (d) ambiguities arising between duties to the institution versus those to the profession itself" (p. 34). Building on Schutz's (1970) notion of subjective meaning, R. Lamb presented the following core concepts in her analysis:

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 (pp. 37-38).

R. Lamb's (1985) results indicated that:

1. given nurses' perceptions of **imposed** relevance, nurses would resort to lower levels of Kohlberg's model of moral reasoning and experience themes of resentment, anger, and revenge, leading to symptoms of severe cognitive dissonance and unsatisfactory patient care.
2. given nurses' perceptions of **bounded** relevance, nurses would resort to mid-range levels of moral reasoning and experience ethical dilemmas with losses noted in the quality of patient care.
3. given nurses' perceptions of **volitional** relevance, nurses would adhere to higher levels of moral reasoning and experience themes of cooperation and accountability with resultant high quality patient care (pp. 165-167).

R. Lamb's (1985) study marks an important step in nursing research on moral reasoning. Her use of a qualitative exploratory approach resulted in the explication of concepts and themes that elaborated on the situational context of nurses' moral reasoning. This investigator is, however, left wondering why it was that some nurses' perceptions of relevance were different from others. It appears that R. Lamb's study

continues to support the notion of a hierarchy of moral reasoning, with some nurses better prepared to uphold Kohlberg's (1972; 1981) higher stages.

Alternate Approaches to Moral Reasoning. As was illustrated in the previous section, most nursing research on moral reasoning takes direction from Kohlberg's (1972; 1981) cognitive-developmental model. Given that Kohlberg's model does not address themes of responsibility and care for women or address moral action, moral content, concrete information or feelings, the current emphasis on Kohlberg is of some concern to this investigator. It is therefore relevant to examine those nursing research studies on moral reasoning that depart from Kohlberg and attempt to examine the uniqueness of moral reasoning within the context of nursing practice.

In concluding her review of the dominant models of moral development, Omery (1983b) called for further exploration of "the process by which we can expedite more principled thinking in ourselves and in the client" (p. 15). Omery (1985) therefore set out to examine "the composition of the moral reasoning used by nurses when they are faced with a moral dilemma in their professional practice" (p. 3).

Using a phenomenological approach, Omery (1985)

interviewed 10 nurses working in staff nurse positions in an ICU. Major characteristics of nurses' moral reasoning included "principles, mediating factors, and modes of reasoning" (p. 6). Omery identified two unique modes of reasoning as including accommodating and sovereign modes of reasoning (p. 7). "In accommodating reasoning, reasoners adjusted, adapted, or reconciled their moral judgements to conform with the perceived norm of the dominant group. . . . Sovereign reasoners based their moral judgement on self-chosen moral principles which were valued by that individual" (Omery, pp. 7-8). Omery noted that the majority of the nurses interviewed were sovereign reasoners. Nurses' choice of principles on which to base their decisions were influenced by mediating factors, which "would compel or restrain the moral reasoner in their judgement to apply a particular moral principle" (p. 8). Mediating factors included objective facts, specific individuals, and interpersonal dynamics (pp. 14-15).

In comparing her findings with the established models of moral reasoning, Omery (1985) noted a similarity in that the modes of reasoning were "qualitatively different from one another" (p. 10). In other words, sovereign reasoners clearly implemented a

different kind of process than that of accommodating reasoners. This is similar to the differences in processes noted by Kohlberg (1972; 1981) between his stages. However, Omery's findings did not indicate that the modes were developmental or mutually exclusive (p. 10). In comparing her findings with Gilligan's (1977), Omery noted similarity in that the principle of responsibility was "identified in the thinking of all the reasoners" (p. 11). Responsibility for sovereign thinkers also included responsibility for self (p. 12). However, the principle of honesty was also fundamental for all the reasoners. This finding again reflects nurses' concerns about the importance of disclosure with their patients and families.

What we see in Omery's (1985) work, then, is an emphasis on situational constraints in terms of mediating factors, as well as a focus on the principle of honesty. Challenging the adherence to traditional ethical principles and cognitive developmental theories, Omery concluded that it "would seem to behoove nurse philosophers to begi[n] to question the traditional dialogues" (pp. 20-21).

A second nursing research study that challenged the traditional dialogues was undertaken by Wilkinson (1985). Wilkinson set out to generate "substantive

theory about the relationships between the moral aspects of nursing practice and the quality of patient care" (p. 1). More specifically, Wilkinson's purpose "was to explore the phenomenon of moral distress as experienced by staff nurses in the context of their practice" (p. 1). Wilkinson used Jameton's (1984) definition of moral distress as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, p. 6).

Wilkinson (1985) employed a "survey approach . . . to yield qualitative data" (p. 32), and interviewed 24 nurses, 13 of whom worked as hospital staff nurses, and 11 of whom had left the bedside (p. 34). Wilkinson's classification of the cases of moral distress included "coding patients who are dying" and "prolonging life . . . when there is no hope for meaningful life" (p. 55). "Pulling the plug or 'No Code' orders" was also a category, but indicated nurses' difficulty when treatment measures were withdrawn (p. 55). This finding is thus similar to one of Fenton's (1987), and supports the premise of this thesis that we cannot assume how individual nurses will interpret the ethics of nursing patients experiencing prolongation of the process of dying.

Wilkinson (1985) reported that moral distress arose out of patient care situations in which a moral issue was embedded, most commonly "harm to the patient (in the form of pain and suffering) and treating the person as an object (dehumanizing). Other moral principles involved were: use of scarce resources, killing, patient autonomy, lying, and failure to benefit" (Wilkinson, p. 68). Moral distress hinged on nurse's **perceptions** of the situational constraints more than the actual constraints. Major sources of situational constraints included physicians, nursing administration, hospital policy and administration and fear of lawsuits (Wilkinson, p. 74). Lack of support from peers was also an important source of perceived constraints (Wilkinson, p. 74). Similar to R. Lamb's (1985) findings with nurses who had perceptions of imposed relevance, Wilkinson's respondents reported experiencing feelings of anger, frustration and guilt in situations that created moral distress (p. 96). Interestingly, "subjects who perceived the physician as 'the decision-maker' and the nurse as 'order-follower' experienced less **guilt** than those with a strong feeling for nursing autonomy and personal moral responsibility" (Wilkinson, p. 96).

Wilkinson's (1985) findings indicate that nurses'

responses are to untenable patient care situations. Anger, frustration and guilt appear to arise because the nurse is unable to fulfill her role. In contrast with many other studies, Wilkinson's results indicate that nurses' ethical difficulties do not reside in nurses' moral reasoning abilities per se, but rather in their experiences of untenable patient care situations.

Wilkinson (1985) further indicates that "nurses' wholeness is damaged by frequent moral distress and the resulting psychological disequilibrium", although the effect on patient care was difficult to determine (p. 115). It would thus appear that nurses' responses to moral distress as described by Wilkinson are similar to nurses' responses as described in the burnout literature. /

Summary of Nursing Research on Moral Reasoning. In review of the nursing research on moral reasoning, we find that studies implementing Kohlberg's (1972; 1981) model demonstrate higher hypothetical moral reasoning abilities associated with increasing levels of nursing education. There is growing interest in the nursing education community to promote improved moral reasoning of nurses vis-a-vis Kohlberg's model. However, nursing research has also shown that nurses' moral choice may

not translate into moral action, probably due to nurses' perceptions of situational constraints. There is some indication that situational constraints may also entail role conflict for nurses (Ketefian, 1985). R. Lamb's (1985) study indicates that nurses' abilities to implement the higher stages of Kohlberg's model will be contingent on their perceptions of their own equality with other professionals in their milieu.

Two recent nursing studies (Omery, 1985; Wilkinson, 1985) adopt alternate approaches that further explore nurses' moral reasoning. Omery's study postulates a different model of moral reasoning that places emphasis on situational constraints and focuses more on the principle of honesty. Wilkinson's study indicates that nurses experience moral distress when they are unable to translate moral choice into moral action. Moral distress is thought by Wilkinson to damage nurses' wholeness.

Given current models of moral development that fail to fully explain nurses' moral behavior and given the importance of individual nurses' values and perceptions of situational constraints, we lack a unified approach to understanding nurses' moral reasoning. Hence, we cannot assume what individual nurses' moral reasoning will be in relation to prolongation of the process of

dying of their patients. Therefore, this study will attempt to uncover the ethical perspectives of nurses, including their perspectives of their moral choices and moral action.

Summary

The purpose of this chapter has been to provide a review of literature related to the conceptualization of the problem statement in Chapter One: Introduction. Pertinent research and theoretical works were explored to further substantiate the conceptualization. In Chapter Four: Presentation and Discussion of Accounts, the investigator will take direction from the accounts to re-examine the literature reviewed and to incorporate additional works to enhance the discussion.

Pertinent literature on the ethical ramifications of prolongation of the process of dying was explored in terms of related ethical issues and related ethical research. Prolongation of the process of dying was identified as an ethical problem arising in the context of critical justification of human beliefs in an attempt to determine moral value or disvalue of the performance of the health care system. Ethical issues, or some of the more abstract notions within which the ethical problem of prolongation of the process of dying

is subsumed, included the definition and determination of death, euthanasia, and treatment abatement.

Related ethical research focused on descriptions of nurses' experiences in ethical situations, and was approached first by examining early studies of the ethics of nursing practice, secondly by examining the ethics of resuscitation, and finally by examining recent studies of nurses' ethical perceptions. In review of the early studies of the ethics of nursing practice, a large survey (Nursing '74a & b) indicated that nurses felt frustrated by their inability to intervene in the patient's behalf, and felt concerned about prolonging life with artificial means. A second survey (Allen, 1974) identified nurses as experiencing situations in which their care of patients was in conflict with other sources. A third study (Davitz & Davitz, 1975) emphasized the emotional involvement experienced by nurses working with patients who are suffering, particularly those patients who are dying.

The studies reviewed on the resuscitation of critically ill patients illustrated that considerations such as quality of life and proxy decision-making may be taken into account, but that treatment abatement in terms of resuscitation may take place without withdrawal of other technological interventions.

Resuscitation decisions appeared to be of concern to nurses, and the care of patients designated as 'do not resuscitate' was seen to absorb significant nursing resources in the ICU.

Recent research on nursing was noted to be focusing more purposefully on nurses' ethical perceptions. Prolongation of the process of dying emerged as a central ethical problem, and became increasingly clarified in terms of nurses' concerns about disclosure to the patient and family, loss of patient dignity, patient comfort, violation of patient's rights or wishes, and family suffering. Nurses' perceptions of prolongation of the process of dying were embedded in the context of situational constraints such as conflicts with physicians and lack of administrative support. Nurses' responses appeared to evolve over time, and incurred significant emotional involvement.

In order to understand how nurses are believed to make decisions in the context of an ethical problem, literature was examined in terms of nurses' moral reasoning. Theories of moral development were reviewed, with the conclusion that the dominant cognitive development models give us direction to look at the implementation of the principle of justice and to look at themes of responsibility and care for

women. We are left with little direction in terms of men's reasoning vis-a-vis responsibility and care. With both sexes we lack direction to understand moral action, moral content, concrete information and feelings in terms of moral reasoning.

Nursing research on moral reasoning included studies implementing Kohlberg's (1972; 1981) model that demonstrated higher hypothetical moral reasoning abilities associated with increasing levels of nursing education. However, nursing research has also indicated that nurses' perceptions of situational constraints often mean that moral choice is not translated into moral action. A consequence of nurses' inability to translate moral choice into moral action may be moral distress; a consequence that may damage nurses' wholeness and lead to burnout and attrition.

Conclusions

Throughout this review of related literature we have recurrent pictures of critical care nurses bound by situational constraints. In the ethical literature, situational constraints such as conflicts with the physician and lack of support from administration give rise to ethical problems. These situational constraints are paralleled in the stress and burnout literature. Burnout and attrition have come to be

viewed as nurses' responses to ethical problems such as prolongation of the process of dying. However, it is not clear from the literature what other kinds of responses nurses may make to ethical problems such as prolongation of the process of dying. In the moral reasoning literature, situational constraints such as lack of support from peers will mean that critical care nurses are often not able to translate moral choice into moral action.

Also emphasized throughout this literature review is that we cannot understand situational constraints unless we understand individual nurses' perceptions of those constraints. Perceptions of ethical problems, and similarly perceptions of stress, appear to be closely linked with nurses' attempts to cope with those perceptions. Perceptions and coping appear to change over time.

One of the strongest pictures in this literature review has been the emotional involvement of nurses in providing care to their dying patients. To reiterate Davitz and Davitz's (1975) conclusion, "[p]erhaps the only conclusion that needs to be drawn is a reaffirmation of the necessity to continue, and even expand, our concern for those who face the fact of morality in their everyday professional lives" (p.

1510).

Within this thesis, that concern has led to a research question that seeks to improve our understanding of nurses' ethical perspectives of nursing dying patients in a critical care setting. Nurses' ethical perspectives will entail nurses' knowledge of and feelings about their experiences caring for patients undergoing prolongation of the process of dying within a situational context. Perspectives will also entail nurses' perceptions of their moral choices and moral action. It is hoped that including nurses' knowledge and feelings as well as nurses' perceptions of their moral choices and moral action will also begin to uncover nurses' responses to their ethical perspectives.

CHAPTER THREE:

METHODOLOGY

Introduction

Phenomenology was chosen as the methodological perspective for this thesis in order to provide a full and accurate description of individual nurses' ethical perspectives. Given phenomenology's emphasis on the construction of meaning within an intersubjective social reality, the investigator felt that a phenomenological approach would best explore the multiple facets of nurses' ethical perspectives. Furthermore, as a branch of existentialism, phenomenology directed the investigator to seek to understand nurses in "concrete lived situations and lived moments" as well as nurses' responses to those moments (Rieman, 1986, p. 89).

This chapter will explain the application of phenomenology as a methodology for this thesis. Therefore the investigator will explain the selection of the study group and the process of data collection and analysis.

Selection of the Study Group

Introduction

Phenomenology represents an inductive approach to theory, which indicates that meaning is sought from

data (Morse, 1986, p. 182). The selection of a study group, therefore, seeks to obtain participants who are qualified in terms of their knowledge base and receptivity to represent that meaning (Anderson, 1985; Morse; Oiler, 1982). For the purpose of this thesis, qualified participants were those nurses who had experience nursing dying patients in critical care settings and who were willing to be interviewed.

The use of phenomenology as a methodology seeks to obtain data that are "comprehensive, relevant and detailed", so a small sample size is chosen initially for in-depth interviews (Morse, 1986, p. 183). Given concurrent data collection and analysis, sampling of participants and data collection "ceases when the [data] is complete, does not have gaps, makes sense, and has been confirmed" (Morse, p. 184). Sampling for this thesis meant choosing an initial seven participants for in-depth interviews. As the interviews progressed, it became apparent that the analysis required a participant to provide additional data. Therefore an eighth participant was added.

Criteria for Participation

Selection of participants met the criteria of appropriateness and adequacy described by Morse (1986):
"Appropriateness refers to the **degree in which**

the method of sampling 'fits' the purpose of the study as determined by the research question. . . . Adequacy refers to the sufficiency and quality of the data" (Morse, p. 185). In terms of this thesis, ensuring appropriateness meant that nurses who could best describe the experience of nursing dying patients in a critical care setting were chosen. Ensuring adequacy meant that an additional participant was added, and most participants were interviewed two to three times.

More specifically, nurses who were currently or had recently been employed at the bedside in a general adult ICU or adult surgical ICU in a tertiary care hospital for at least one year were chosen. Prolongation of the process of dying takes place most frequently in general adult ICU's, and therefore most participants spoke of experiences in that setting. The eighth participant was chosen to represent someone with less than a year's critical care nursing experience to further explore how nurses' experiences changed over time. Nurses were also chosen from two different tertiary hospitals from within the city in order to represent experiences with different kinds of patient populations and organizational climates in relation to prolongation of the process of dying. To add to the quality of the data, nurses' accounts of previous

experiences in neonatal, pediatric and open heart surgical ICU's in other hospitals were included.

Female nurses were selected because of the conflicting views of moral reasoning discussed earlier in Chapter One and Two. The investigator did not wish to address potential gender differences within this thesis.

One final note in terms of criteria for participation in the study group involved the investigator's previous role in one of the hospitals as a critical care instructor. The phenomenological method has been described as "approaching the phenomenon with no preconceived expectations or categories . . . and then exploring the meaning of the experience as it unfolds for the participants" (Omerý, 1983a, p. 54). In order to minimize preconceived expectations between the investigator and participants, the investigator selected participants from her previous hospital whom she had not supervised. Given that the investigator had ceased employment in the hospital at the time of the study, the investigator did not find the interviews with participants from her previous hospital to be constrained.

Procedure for Participant Selection

The procedure for participant selection primarily

involved a snowball sampling technique. Morse (1986) describes the snowball sampling technique as follows:

[This] method of sampling is to initially select informants who are receptive and knowledgeable; after the selected informants are interviewed, they are requested to introduce the researcher to other informed persons for subsequent interviews. In this sampling design, receptivity problems are partially overcome, as some trust is established through introductions by a mutual acquaintance, and the researcher is using the first informant's judgement that the next informant has some knowledge of the topic (p. 184).

Initial recruitment of selected participants took place by advertising through the local chapter conference of the Canadian Association of Critical Care Nurses (C.A.C.C.N.) (see Appendix A). Those nurses interested in participating in the study were asked to contact the author by telephone, and a letter of information was given to nurses expressing interest at the C.A.C.C.N. conference (see Appendix B). A second advertisement was placed in a local C.A.C.C.N. general membership mailing a month later. Two participants were obtained through this initial recruitment.

Subsequent recruitment of a third participant took

place through referral by a nursing associate. This third participant then introduced the researcher to four other nurses for the study, thereby facilitating receptivity and trust of the next four participants. The eighth participant was obtained through referral by another nursing associate.

All eight participants volunteered to be interviewed for the study, and were given a letter of information and asked to sign a consent form (see Appendix B).

Characteristics of the Participants

Within this section of Chapter Three, characteristics of the participants will be summarized to provide a context in which to view each participant's interpretation of the meaning of her experiences. Each participant has been identified by a code (P1* through to P8) to enable identification of the range of responses in Chapter Four.

Participants' years of experience in critical care nursing ranged from less than one year (P8) to seven years. Six participants (P3, P4, P5, P6, P7 and P8) had critical care nursing experience in one general adult ICU. One participant (P2) had critical care

P* = Participant

nursing experience in a general adult ICU, an adult post-open-heart surgical unit, and an adult surgical ICU. One participant (P1) had critical care nursing experience in a pediatric ICU and an adult surgical ICU.

The levels of education for the participants included 6 nursing diploma graduates and 2 nursing baccalaureate graduates. Four of the participants had certificates from formal critical care nursing training programs.

All eight participants were female.

Ethical Considerations

The investigator sought approval through the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects, and the local chapter of the C.A.C.C.N. before initiating this study (see Appendix C). This ensured methodological, administrative, and protection of human rights clearance (Diers, 1979). Once approval was granted, the investigator advertised for participants through the local C.A.C.C.N. (see Appendix A) and by referral through nursing associates.

Ethical considerations also involved each participant's right to informed consent, and right to privacy (Diers, 1979). Therefore, nurses who responded

were given a letter of information describing the intent and design of the study (see Appendix B). The author clarified any questions and determined if nurses wished to participate during an initial meeting. Those agreeing to participate were asked to sign a consent form (see Appendix B) before the first interview. Nurses had the right to refuse to participate, the right to refuse to answer any questions, and the right to withdraw from the study at any time. Confidentiality of results was maintained by coding the nurses' names for the purposes of the transcripts, and nurses were asked not to mention names during the interviews. Any names accidentally mentioned were deleted from the transcript. Published and unpublished materials do not include names of persons or institutions.

Data Collection

Within a phenomenological perspective, data consists of "experiences as shared and understood by the participants and the observer" (Rist, 1979, p. 20). This meant that data collection for this thesis consisted of a series of unstructured interviews (see Appendix D for trigger questions). Initial interviews in phenomenological research generate a broad scope of ideas and concepts, and one or two subsequent

interviews are scheduled with participants to validate and expand on concepts arising out of the interview data (Anderson, 1981a, 1985; Anderson & Chung, 1982; Glaser, 1978; Lindemann, 1974; Morse, 1986). All eight participants had initial interviews that lasted from 45 to 90 minutes to generate a broad scope of ideas and concepts. Validation and expansion took place by scheduling second interviews with seven participants (one participant was no longer available), and third interviews with three participants. Second and third rounds of interviews also lasted 45 to 90 minutes. Given a process of concurrent collection and analysis of data, data collection ceased when Morse's (1986) criteria in terms of the data being complete, making sense, and being confirmed were met. A total of 18 interviews were thus conducted over a six-month period.

The participants were offered their choice in terms of where the interviews were to be conducted. Seven participants chose to be interviewed in the investigator's home, and one participant chose to be interviewed in her employing agency. Permission was obtained from the hospital administration before conducting interviews for the latter. Each interview was audiotaped, with a typed transcript made for purposes of analysis. Participants were told that they

would have access to their transcripts and thesis results upon request at the completion of the study.

Data Analysis

The intent of data analysis within phenomenology is to move from the concrete towards the abstract in order to construct an exhaustive description (Riemen, 1986). Data analysis does not move towards the construction of a formal theory, but rather constructs a description of how people interpret and give meaning to their situation within an intersubjective reality (Anderson, 1981a & b; Anderson & Chung, 1982; Benner, 1985; Davis, A., 1973/1978; Oiler, 1982; Omery, 1983a; Reimen, 1986; Rist, 1979).

In order to analyse nurses' accounts and arrive at an exhaustive description, the investigator utilized Giorgi's (1975a) approach to phenomenological data analysis. Giorgi explains his approach as follows:

1. The researcher reads the entire description straight through to get some sense of the whole
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2. The researcher reads the same description more slowly and delineates each time that a transition in meaning is perceived . . . [and] obtains a series of meaning units or constituents
3. The researcher then eliminates redundancies,

but otherwise keeps all units. He then clarifies or elaborates the meaning of the constituents by relating them to each other and to the sense of the whole

4. The researcher reflects on the given constituents, still expressed essentially in the concrete language of the subject, and transforms the meaning of each unit from the everyday naive language of the subject into the language of psychological science

5. The researcher then synthesizes and integrates the insights achieved into a consistent description (pp. 74-75).

The process of analysis in this thesis involved a constant comparative analysis (Glaser, 1978; Lindemann, 1974) between the meaning units as presented by the participant and conceptualized by the investigator. Interviews with participants therefore moved from open, reflective listening by the investigator towards a process of clarification with participants to validate the investigator's interpretations. Constant comparative analysis also meant that the investigator moved between the meaning units and the literature. Once the interviewing was completed, the author continued to return to the literature to further

explore the identified meaning units.

Moving from the concrete data of the initial interviews towards increasingly abstract meaning units validated by the participants and the literature resulted in the construction of an exhaustive description of critical care nurses' experiences nursing dying patients in a critical care setting. Chapter Four will explore nurses' accounts of nursing dying patients in a critical care setting and will illustrate the construction of the resultant description.

CHAPTER FOUR:
PRESENTATION AND DISCUSSION OF ACCOUNTS

Introduction

This section of Chapter Four will present an introductory description of the nurse participants' ethical perspectives on nursing dying patients in a critical care setting. This introduction will be built into an exhaustive description through the interpretation and discussion of accounts later in this chapter.

On the whole, nurses' ethical perspectives on nursing dying patients in a critical care setting centered around a theme of senselessness. Senselessness was described by nurses in terms such as "fruitless", "going nowhere" and "self-defeating". Senselessness illustrated the conflicts experienced by nurses as they cared for patients undergoing prolongation of the process of dying, and was associated with feelings of anger, frustration and powerlessness. The conflicts experienced by nurses were comprised of multiple ethical dilemmas, or choices between equally compelling or unsatisfactory alternatives (Aroskar, 1980; Smith & Davis, 1980). These dilemmas thus constituted some of the concrete conflicts arising out of the overall ethical problem of

prolongation of the process of dying (Curtin, 1982a; J. Ericksen, personal communication, June 12, 1987).

More specifically, nurses described the theme of senselessness in terms of three major concerns. These concerns were: (a) a senseless decision-making process; (b) experiences of patients and families that were seen by nurses as senseless; and (c) activities nurses found themselves involved in to implement treatment regimes that were seen by nurses as senseless.

Nurses' ethical perspectives on nursing dying patients in a critical care setting centered around a theme of senselessness. However, nurses' ethical perspectives also emphasized their attempts to cope with senselessness. Coping with senselessness was described by nurses in terms of finding new meanings. Given an understanding of meaning as the individual's personal interpretation of events and relationships which provides direction for and is directed by action (Kelly, G. A., 1980; Klinger, 1977; Shepherd & Watson, 1982), finding new meanings provided nurses with new personal interpretations that provided new directions for actions. Thus, as nurses acted they reformulated their interpretations, and so constructed further directions for action. Mishler (1979) reminds us that

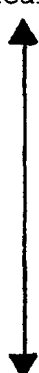

any notion of meaning must be context-dependent. Nurses' personal interpretations and directions for action will therefore be explored in this Chapter within the context of each nurse's unique experiences.

Finding new meanings was described by nurses in terms of shifting focus, or shifting their focus of action. Shifting focus included: (a) shifting focus from the implementation of treatment regimes to patient comfort; (b) shifting focus to support of the family; and (c) shifting focus to nurses' own personal philosophies.

Nurses described their ethical perspectives as processes occurring over time, and subject to a variety of influences. Influences included such things as peer support, the workload in the patient care situation and the cultural background of the patient and family. Nurses therefore experienced a circular process of evolving meanings as they responded over time in the context of a variety of influences. In other words, nurses did not shift focus and arrive at a finite end-point of better or worse, meaning. Rather, nurses' experiences were that they were constantly evolving new meanings that were qualitatively different from each other. The diagram in Figure 1 summarizes the overall process of nurses' ethical perspectives.

Figure 1:

**Nurses' Ethical Perspectives on
Nursing Dying Patients in a Critical Care Setting**

ETHICAL PERSPECTIVES	CONCERNS	INFLUENCES
<p>THEME OF SENSELESSNESS</p> <ul style="list-style-type: none"> - Conflicts - Ethical Dilemmas 	- A SENSELESS DECISION- MAKING PROCESS.	<ul style="list-style-type: none"> - Cultural background of the patient and family. - Legal climate of the patient care situation.
	- EXPERIENCES OF PATIENTS AND FAMILY MEMBERS AS SENSELESS.	<ul style="list-style-type: none"> - Context of the patient's life history. - Nurses' own identification with that life history.
	- NURSES' ACTIVITIES AS SENSELESS.	<ul style="list-style-type: none"> - Length of exposure of nurse to patients experiencing prolongation of the process of dying.
ETHICAL PERSPECTIVES	SHIFTING FOCUS	INFLUENCES
<p>COPING WITH SENSELESSNESS</p> <ul style="list-style-type: none"> - Finding new meanings 	- FOCUS ON PATIENT COMFORT.	<ul style="list-style-type: none"> - Nurses' use of analgesia. - Nurses' inability to communicate with most of their patients.
	- FOCUS ON SUPPORT OF THE FAMILY.	<ul style="list-style-type: none"> - Nurses' development of increasing competence in their nursing practice. - Cultural background of the family. - Workload in the patient care situation. - Nurse's perceptions of support from others.
	- FOCUS ON PERSONAL PHILOSOPHY	<ul style="list-style-type: none"> - Amount of energy for self.
EVOLVING MEANINGS		

Construction of Accounts

The previous chapter described the process of data analysis as a progression moving from the concrete meaning units of participants towards more abstract, descriptive meaning units. This was paralleled by an interviewing process that moved from open, reflective listening by the investigator towards clarification and interpretation with the participants of the identified meaning units. It is the intent of this section of Chapter Four to examine that interviewing process more specifically in terms of the process of construction of the participants' accounts.

The initial interviews with participants generated a broad scope of ideas, with participants speaking freely about their ethical perspectives on nursing dying patients in a critical care unit. The following excerpt from an initial interview will illustrate how each participant began to freely describe her experiences from the outset of the first interview. The investigator's participation consists of responses to promote an open description from the participant:

I:* There is no one viewpoint that we ask
people to represent and what it is is to just get

* I = investigator

people to describe their feelings and their interpretations of different situations and through that then look at how that fits with ethical theory. But, did you want to ask anymore about that?

P4:** No, I was basically wondering how you were going to go about, like do you ask certain questions through the interview and then you want me to respond, or you just want me to . . .

I: No. It's just very much for you to talk about what it's like to look after people who you believe are dying and you're still pursuing treatment with them in an intensive care unit. That's why this methodology works well because if I ask you specific questions it would mean that I thought I knew what some of the questions are. Do you follow what I mean?

P4: Oh yeah, okay. . . . Yeah, well I guess I find that's one of the biggest problems I find working in an Intensive Care Unit is a lot of times there's no support from the upper echelons and the fact that we're looking after a lot of people that

****** P = participant

4 = participant's identification number

are dying, and I think we're looking after a lot of people that are dying and I think it's fruitless and there's no support for the family per se. When these people are dying there's no, I don't think that anybody is being totally honest with the families. I find I'm starting to do more so, tell them like it is, even though I'm not supposed to be, I'm supposed to wait for the doctors to tell and this is the way it is. And that they aren't totally oblivious at how grim the picture is and I know and they have a feeling what's going on but they're not definitely sure. It's . . . some doctors are better than others and that's what I find frustrating

As can be seen, this participant immediately spoke of what was of most concern to her in nursing dying patients in a critical care unit. The resultant broad scope of ideas and concepts in the first round of transcripts was then analysed by the investigator in terms of concrete meaning units. These meaning units remained in the language of the participant. For example, in the transcript above, meaning units such as "no support", "upper echelons", and "fruitless" were drawn out by the investigator to be further explored with the participant in a subsequent interview.

The second round of interviews involved a process of clarification by the investigator to validate the investigator's understanding of the meaning units identified in the first round. This offered participants the opportunity for further clarification and elaboration. The following excerpt from a second interview will illustrate the process of clarification between the investigator and participant:

I: Okay, one of the things that you started talking about that I think was a really important word, was "senselessness" and I'll just sort of let you know in what context as I go through this so you can remember. You said that one of your feelings was that there was a lot of senselessness with looking after people in critical care who weren't gonna go anywhere and that that was what everybody calls "burnout", and I think the phrase you used was "whole rows of patients going nowhere", and I wondered if you could elaborate a little bit on what senselessness means to you and whether that meant 'rows of patients going nowhere'? If you could just talk about that a little bit more.

P1: I guess that the senselessness of the sort of endless treatment, but more than that, the sort

of real lack of quality of life for them, I think we all have a really limited life span and I think that even if you just have one day to live, for one more day, doesn't mean that it's senseless, it's just the quality of that day. And I think that if we sort of keep on giving the kind of care that renders no sort of interpersonal reactions, for instance, the children that I was thinking of were the long-term ventilated children who couldn't even be held by their parents or have any kind of social interaction or anything, and there were many of them like that, that were, that just couldn't be handled or touched or have any kind of growth or any feeling or anything quality to one, to any of their days, that really seems, that's what sort of really bothers me.

I: Right. So that it was the interpersonal, the lack of interpersonal relationships which you felt meant that there was a lack of quality of their life?

P1: Yeah, and just complete lack of any sort of sensory input or any enjoyment, you just had to wonder, you know, what they were lying there thinking or feeling or, you know, and with no particular end in sight,

An important feature of the process of clarification was that the participant and investigator clarified meaning units in context. For example, in the previous transcript, as the investigator sought to further develop an understanding of the meaning unit of "senselessness", she reminded the participant that she spoke of it in relation to "rows of patients going nowhere" and "burnout". The second round of transcripts thus continued what Schutz (1932/1967a; 1954/1967b) has called an intersubjective construction of reality. The investigator's focus was to understand "the subjective meaning of the actions of human beings from which the social reality originates" (Schutz, 1954/1967b, p. 387).

The process of data analysis involved a constant comparative analysis between the meaning units as presented by the participant and conceptualized by the investigator. Constant comparative analysis also meant that the investigator worked between the meaning units and the literature. Moving from the concrete meaning units towards a more abstract description of critical care nurses' experiences nursing dying patients in a critical care setting necessitated a process of validation with participants. As the investigator constructed a more abstract description, she returned

to the interviews to validate the evolving description. This validation took place during a third interview or at the end of a second interview with participants. The following transcript excerpts will give examples of the process of validation:

I: I think the overall common thread that stands out, if I was to sort of title the thing . . . is that, as far as nurses' feelings about what's going on with looking after people who are dying in critical care, that the way that they look at that or that they deal with that . . . is to look at it and basically try and find some meaning in it, like, what are those things that will be most important to them in that situation and try and find a way of finding some kind of positive meaning out of it. And what it's appearing is that that's not just . . . this is what you see, this is what you decide, that it's probably a process that takes place over quite a long period of time as people are in critical care, so that sort of construction of meaning or finding some sense out of the whole thing is kind of the overriding umbrella. Does that, do you understand what I'm saying?

P4: Yeah, it hits the nail right on the head,

like why am I doing this? Why am I doing it?
Where are we going? Who's benefitting?

I: How is this sounding so far, by the way, is this ?

P1: Yeah, I think being able to construct meaning, that sounds good . . . the senselessness, and again, I think that's probably one of the core things that make us feel so awful about things sometimes, all the senselessness, it is, it's a really big feature because I felt quite senseless about what I'd done those two days and I thought gosh, I'm sure this is very hard to look after these people day in and day out and I think that patients particularly who are being weaned and you know they'll come and say, Oh cut back on sedation. and don't give him too much and Oh-h-h! Give me a break!

The process of validation illustrated above involved the investigator presenting her description to the participants and seeking feedback on it. In the process of validation, further clarification of meaning units often occurred, for example P1's use of a recent clinical illustration in terms of senselessness.

At times, the process of validation was strongest

with a participant in terms of a selected aspect of the description. The following transcript excerpt illustrates this:

I: [re: changing personal philosophy] And that was very important to you, was it, do you think, that personal philosophy? Like your face lit up when I said it, I was wondering . . .

P6: Oh no, I was just, you know, as soon as you said personal, how it changes your personal philosophy I thought, wow, that really did hit the nail right on the head . . . Yeah, oh, exactly, it really does, because you see these poor people come in who are these, the best people, you know, really good contributors to society, good family people, didn't drink, didn't smoke, and then through no fault of their own they'd end up, you know, they get hit by a truck or they'd end up getting some terrible disease and you just never knew what was gonna happen to you.

At other times, the process of validation required changing the language of the description for the participants. The phrasing of the meaning units was not always the participant's own, but once re-interpreted, rang true to their experiences. The next two transcripts illustrate the process of

interpretation often involved in validation of the exhaustive description:

I: Alright, so what about the business of how your philosophy is affected, sort of as you're dealing with this. How's that for you? Would you . . . ?

Pl: Can you sort of re-phrase that?

I: One of the things that it seems is that not only is the task to shift focus as to what you can do but also to think about, you start to think about the world maybe in a different way or you, and that that may be a part of it, and I think the way that you had phrased it before was that you can be very privileged to be with people at these times, that that privilege in a sense, and I think what you meant was the learning that you can do. Did you mean that?

Pl: Yeah.

I: That that could be something positive.

Pl: Yeah, I think for myself, I've been exposed in different ways and probably at a fairly formative age, in my middle twenties which is probably, I think age probably has an effect, when you're sort of learning those kind of things, so I came in with quite decided ideas and previous

feelings and so, yes, it was there, and I don't really think it really developed in the situation but that was just because of the way, it wasn't my first exposure to dying people, so, but probably if it is your first exposure, you would hope that people would see it in that light, and I think they do, I think that good communication with relations and being able to support them at that point in time and being there can really make you grow and, you know, develop your own philosophy.

I: And do you see that then as being part of your overall life philosophy, not just your philosophy of what happens at work?

P1: Oh, I think very much so . . . , I think it's certainly affected my whole sort of thinking in my whole life philosophy when I was exposed to dying people and to the things that happen to people along the way, I think, which is interesting, you sort of wonder if some people do just see it in terms of working or whether they actually internalize it.

I: So from your experience you probably wouldn't have described it that way, but are there things that make sense from your own background in

that description that I've given you in terms of senselessness and coping with it?

P8: Oh I think so, I think, well from my experiences, I guess maybe I'll just reiterate what I said before, is that coming in and questioning what I'm doing, does that answer your question?

I: Yeah, exactly, that's all I need to know, . . . but if you're saying that it does follow some of what you've experienced that's basically what I need to know.

P8: I think so, I haven't found, when you use the word senseless, I guess that's, in some cases, what I have been saying, is that, when I talk about there not being a purpose, when you can't clearly see the purpose.

The presentation of accounts to follow in this chapter will offer transcript excerpts from participants' accounts in order to build an exhaustive description of nurses' experiences. Relevant literature from Chapter Two, as well as additional theoretical works, will be incorporated in a discussion of the accounts. The investigator will return to the initial problem statement to draw some conclusions at the commencement of Chapter Five.

Interpretation and Discussion of Accounts

Theme of Senselessness

Introduction. Nurses' ethical perspectives on nursing dying patients in a critical care setting centered around a theme of senselessness; a theme that illustrates the conflicts, or ethical dilemmas, inherent in the overall ethical problem of prolongation of the process of dying. Before exploring nurses' descriptions of their ethical dilemmas in relation to senselessness, it will be beneficial to first examine the nature of an ethical dilemma more closely.

Conflicts in ethical dilemmas are often framed in conflicts between rights, duties, and obligations or between ethical principles (Aroskar, 1980; Smith & Davis, 1980). Rights have been defined by Bandman and Bandman (1978) as "an indispensably valuable moral possession" that is the basis of dignity, respect, and self-respect (p. 8). Examples of rights that are relevant to nurses' experiences with patients undergoing prolongation of the process of dying include the right to self-determination, the right to be informed, the right to be free from pain, and the right to die.

"Rights imply corresponding duties on others to enable right-holders to exercise their rights" (Bandman

& Bandman, 1978, p. 8). An ethical duty is mandated by an individual's role, status, or position, and is outlined in the professional code of ethics (Smith & Davis, 1980, p. 1465). Therefore, in terms of the patient's right to die, nurses are directed to "find new ways to preserve human values, autonomy, and dignity" (Canadian Nurses' Association, 1985, p. 7). It should be noted that ethical duties arise from the code of ethics, and are not specified in codes of law (Smith & Davis, p. 1465).

An ethical obligation arises when:

. . . one establishes a relationship based on a commitment that relates to an ethical duty. A nurse incurs an ethical obligation by virtue of the relationship formed with the patient, the institution, and other health care professionals and, perhaps, the patients' family and friends and society (Smith & Davis, 1980, p. 1465).

For example, an ethical obligation in relation to prolongation of the process of dying would arise when a patient's family approach a nurse to say that they cannot understand why their family member is showing no improvement. The nurse would have an ethical obligation to assist the family members to approach the physician for more information.

Finally, ethical principles may be viewed "as governing laws of conduct, as codes of conduct by which one directs one's life or actions, or as generalizations that provide a basis for reasoning" (Davis & Aroskar, 1983, p. 40). Three major ethical principles that are particularly relevant to nurses' accounts in this Chapter include autonomy, beneficence, and justice (Beauchamp, 1982a). Autonomy, also known as respect for persons, directs us to see persons as unconditionally worthy agents with a capacity for rational choice (Beauchamp, p. 26). Beneficence directs us to "abstain from injuring others and to help others further their important and legitimate interests, largely by preventing or removing possible harms" (Beauchamp, p. 28). Justice directs us to give another "what he or she is due or owed, what he or she deserves or can legitimately claim" (Beauchamp, p. 30). More specifically, distributive justice "refers to the proper distribution of social benefits and burdens" (Beauchamp, p. 30). An illustration of how these principles might operate in terms of a prolongation of the process of dying situation would be a nurse's desire to respect the choice of a patient's refusal of surgery (autonomy), but her concerns that the patient will suffer increasing pain without the

surgery (beneficence), and her knowledge that if the patient chooses to go to surgery, other emergency surgeries will be delayed (justice). As can be seen from the illustration, ethical principles often conflict with each other to create an ethical dilemma.

As the theme of senselessness is explored via nurses' accounts, the investigator will uncover some of the ethical dilemmas inherent in the nurses' perspectives. In other words, the investigator will illustrate some of the conflicts between rights, duties, and obligations or between ethical principles inherent in nurses' concerns.

A Senseless Decision-Making Process. Nurses' ethical perspectives of senselessness were described as originating in a decision-making process that they viewed as senseless. This was a concern that was emphasized repeatedly through the transcripts with every participant, and was described in terms of the process by which decisions were made. Inadequate involvement of the patient, inadequate involvement of the family, inadequate involvement of the nurse, and fragmentary team decision-making were all part of nurses' ethical perspectives of a senseless decision-making process.

The following transcript excerpts illustrate

nurses' ethical perspectives of senseless decision-making process in terms of inadequate involvement of the patient:

P2: We had a little old lady that I found really difficult to look after, she was a real sweetheart, . . . but she was chronic lung, smoked all her life and I mean she was like seventy, almost eighty, and was trached and I mean you take her off and T-piece [a weaning mode] for five minutes or whatever and she'd go blue. But we continued on to ventilate this lady, we continued on with her treatment, yet if she got an infection we wouldn't treat it, and so that took three months, with her on the ventilator and living through hell, and her trying to pull her trach out because she wanted to die.

I: Did she tell you she wanted to die?

P2: Yes. And we continued on. But everybody figured she was old and her CO₂ was up and she didn't know what she was talking about so we would continue on.

I: So she was considered not competent because of her CO₂?

P2: Right, yeah.

P4: One of the biggest ones that we have a hard

time dealing with in ICU is the leukemic patients, bone marrow transplants, and acute and mild leukemia, and not one of them has ever made it out of ICU, once they come to ICU they never make it out. And we get the attitude, oh shit, another leukemic's coming in. But it's only because we know that it's frustrating, the family's down there and they are used to have so much support up on [the ward] and they have gone through the stage and all of a sudden they end up in ICU, but they're not told when they go through all this treatment, you know, once they get graft vs. host, that if they end up in ICU that they're not going to make it out. . . . All of a sudden you see these patients that come down and they're with it when they come down, they know what's going on and they're never consulted as far as I can see. It's always when it's too late, when they're intubated and ventilated and you've got them so sedated that they can't make a decision themselves and it's up to the family to make a decision.

P5: See, cuz this man did choose to have no resuscitation.

I: Oh, did he?

P5: Yeah. And we're doing it strictly for the family and we can't take his decision as the final, this is it, he's chose that, Oh, we're not going to intubate him or anything, you know, cuz he arrested on the floor and that was it, and he knew his chances of survival once admitted to the hospital were marginal and he didn't want anything to be done, you know, and unfortunately it was done. But I mean you can't rely on that, you don't know how the man was feeling at the time or, you know.

I: So the whole question of whether he was competent to say that, that's another problem?

P5: Yeah. So it's a really individual thing that you're dealing with . . .

As can be seen from the previous transcripts, patient participation in decisions regarding the discontinuation of treatment was described as not taking place, frequently because of presumptions of patient incompetence. The first transcript illustrates that nurses did not always agree that the patient was incompetent; a conflict between the patient's right to self-determination and the nurses' obligation to follow the physicians orders. The third transcript reaffirms the difficulties in determining a critically ill patient's competence described in Chapter Two (Cassell,

1986; Youngner, 1986).

It is interesting to note that a recent field-work study of decision-making within the health care system has noted an overall lack of patient participation (Degner & Beaton, 1987). Within this thesis, lack of patient participation in decision-making was seen by nurses as contributing to a senseless decision-making process.

Inadequate involvement of the family in decision-making was a major focus of nurses' descriptions. The following transcripts illustrate nurses' perspectives of inadequate involvement of family members:

P5: Well I just, sometimes I feel that the family members don't get all the information, whether, and I think when you're consulting a lot of services and say they're in for their Triple A [Abdominal-Aortic-Aneurysm] repair but somehow they end up becoming obtunded and you don't know why, and neuro comes in to see them and all of a sudden now they've got some sort of blood dyscrasia and hematology is in to see them and I think the family has a right to know what is going on - the total picture, you know, the total care, not just, you know, the Triple A has been fixed but now it's

something else, you know, that's killing the patient. And I think a lot of family members will talk just to [the physician] and say, "Yeah, well, you know, we've done everything we can" and this and that, and I mean, it's true, we have done everything we can, but I still feel that family members should ask, "Well, we'd like to speak with the Infectious Disease's people, we'd like to speak with the neurologist that has come in to see him." Sometimes I find that hard because there's so many services that have come in . . .

I: That the family never get the full picture?

P5: That the family never get the full picture, you know, as I say they come in for the Triple A and the Triple A is repaired so they don't understand why the patient is now dying because he was here for his aneurysm but now you say it's repaired, you know, now why is he dying, sort of, why ?

P2: . . . or family members who have said, "We've discussed this and because, you know, they're 85 years old, or 80 years old, or whatever, and that if it ever came to the point where he'd have to be on a ventilator we've discussed it and

we don't want it to be that way." And then them being talked out of it.

I: Right, I think I understand what you mean by [that] but can you talk more about what usually happened, was it the physicians talked them out of it or ?

P2: Yeah, usually, or they maybe belittled things and said, Well this will just be for a little while, or maybe it's maybe they tell them the truth but the people don't, what the doctor's saying and what the people are hearing aren't the same thing.

I: So there's a lack of clarification?

P2: Yeah, and so they, they don't clarify what each other's saying and what other people think. I remember one Oriental lady that we had that, she had to have a lobectomy done and they told her it would just be a tiny little cut and woo-of.

I: So it's not just that they don't understand, but it's also how the information is presented?

P2: Yeah, and so, you know, whatever the doctor really said, but this is what the family understood, was that there was just going to be a little cut and they'd take out this piece of lung and she'd be fine. Well, she was ventilated and

for I think it was something like three months

. . .

Nurse's descriptions of inadequate family involvement in decision-making frequently centered on partial, poorly presented, or misunderstood information; a violation of the family's right to be informed.

As was illustrated in the first transcript, family members were perceived by nurses as being bewildered by the lack of a comprehensive picture of what was happening to their loved one, often because of the variety of medical services involved in the patient's care. In a foreword to the study cited earlier by Degner and Beaton (1987), Glass (1987) states that the "diffusion of expertise stemming from specialization and layered consultation leaves consumers of health care confused and seldom in control of the decisions which affect their destiny" (p. 3-4). Patients and family members were described by nurses in this thesis as confused and lacking control in decisions to withdraw treatment.

The presentation and discussion of accounts has indicated that nurses expressed concern that patients and families often lacked information to make decisions to withdraw extraordinary treatment measures. There was also concern expressed during one interview that

family members might have been pressured into making decisions to withdraw treatment when they were not ready. A continuation of the transcript cited earlier with P5 presents this concern:

I: And yet, even with that lack of understanding [the family is] in a position where they may be deciding that they don't want to carry on. Is your concern that that may bother them later or ?

P5: I think so, cuz I think a lot of people look at the patient and say, "Oh-h, we don't want any treatment initiated or any treatment started, let's just let her pass away, or whatnot, and I think a lot of families may feel, not coerced into their decision, but hastened into their decision, because it's one, and I hate to say that they're not in need for a bed, but it's sort of . . .

I: There can be a certain amount of pressure?

P5: Yeah, and I think, you know, and even if given the chance this patient would probably pass away within the week, but I mean you've seen something that's come out, you know, and this patient has turned up and gotten better and left the unit, and totally survived.

I: Although even given that it's not so much

the fact that he's going to die, it's how the decision is made that you're concerned about?

P5: Yeah, and I think they say, like on Friday they're given that decision and they'll say, "Okay, well let us think about it on the week-end", or "Family members are coming in from City A", and this and this, and all of a sudden there's a new [physician] on Monday morning and he or she, . . . has no idea what's transpired on Friday, or how this family member has been approached on asking, you know, should we continue on with treatment, and I think there should be some consistency And I think, you know, because they just, as I said, they only get say, you know, they're there for their Triple A and that's repaired and he's repaired it and now all of a sudden they're dying because they're DIC [Disseminated Intravascular Coagulation] so that hematology's there, so you know, later they're going to go home and say, "Well, I didn't get the full picture, I know that the aneurysm was repaired but could the DIC be fixed, I didn't talk to anybody about that", but then there's a lot of people who don't know there's different services, they think that one doctor takes care of

everything, and sometimes I think it's unfortunate that a member of the family is not given that choice to talk with everybody, or you try to get them to meet and it's just . . .

I: So the element of choice and full information's really important in that to you?

P5: Yeah, I think so, you know, in order for that family member to believe in themselves that they made the right decision or, you know, it would be an awful decision to make knowing in 2 years time that, "Well, you know, maybe I should have talked to a hematologist or something", and there's a lot that don't know that there's so many services.

The excerpt from P5 illustrates that nurses' concerns were not about the decisions per se, but rather about what they considered as a senseless decision-making process. This transcript parallels concerns expressed by participants in Fenton's (1987) study that the process of withdrawal of treatment measures violated patient and family's rights to be informed and make informed choices in their care.

A further dimension of a senseless decision-making process in terms of family involvement was expressed by nurses who stated that the family was not always able

to represent the best interests of the patient. The following transcript provides an example:

P5: It really bothers me, this, you know, we had a 96 year old come in and they wanted full treatment and of course she was intubated and the whole bit, at 96, and I just think there's a point in time when a family member has to realize that, you know, at 96, or 82, or 88, I mean I don't know where to draw the line, you can't, well, if you're over 75, well, that's it, the decision's made, you've gotta, it's your time to go, and I just think that family members should be aware of what that patient is going through for their own feelings.

I: For the family members' feelings?

P5: For the family members' feelings. You're now dealing with their choice to make that, to give that care, and that patient has no say, they could be completely blotto, but it's the family members that are asking to give all this care and I'd just like them to be made aware, look this is what we're doing to your mother, you know, we're subjecting her to this test, we're subjecting her to this test, and this test, and this test, only to find out that, you know, I mean, that she's old and her

time has come, you know.

Nurses' perspectives indicated that family members were sometimes unable to represent the best interests of the patient because of lack of information and lack of understanding. Nurses thus experienced a conflict between their duty to preserve the dignity of their patients and their obligation to respect family members' decisions.

Family members were also seen to be confused by their lack of understanding of the information presented to them as well as by the ambivalent actions of the health care team members. To illustrate:

P7: . . . finally we said that there's nothing more we could do, we had a family conference, and there was nothing more we could do with him, and I was involved with that, and hematology was there and they said, you know, it's time for us to let him go, and that, the family didn't say a word and then they asked completely afterwards, you know, like "Well when are you gonna do his bloodwork?" and when are you gonna do stuff like this? And we said, "Well you were just in the meeting, we're not gonna take bloodwork anymore", like this is how if a patient, what they prefer to do which is actually is pretty, they won't turn somebody off, if there's

nothing you can do, they won't turn them off, they won't even put them from 90% to 21% [oxygen] to just basically kill them quickly, painlessly, just woomp, they're gone, they won't do that, they leave everything as is, they won't add anymore inotropes to them, they won't do any blood work, so therefore they don't have any bad, the doctors don't have any bad consciences, but there's nothing they have to order. So it's like the doctors are all of a sudden put in this guilt free zone because . . .

I: They have no information coming to them.

P7: There's nothing sitting here, I can't treat anything, you know, and here you've been bolting this kid with potassium on and on and on and you knew that he was eventually going to infarct from all that potassium. They wouldn't stop any of the antibiotics, they don't start any inotropes, they just leave everything as is, so here's this kid on an assist control of 40, piece of 15, 90% oxygen, you know you're basically beating him to death. We're not doing any bloodwork so of course his platelets, he's eating up platelets so you know that you're just, with each breath we weren't gonna do any chest tubes if he blew a [pneumothorax], like nothing, like basically you were just, seems to me

like the most disgusting way to kill somebody, you know, you still could give him sedation and stuff like that but you're not . . .

I: Must feel like a very grey zone to be in.

P7: Oh, it's horrible. And especially when the family can't accept it, when the family wants you to do things even though they know there's nothing you can do, they want . . .

I: And they still see him on the ventilator and stuff?

P7: That's right.

In the transcript excerpt from P7, ambivalent actions of the health care team members such as not stopping ventilation and antibiotics but not adding inotropes for a falling blood pressure were seen to further confuse family members.

The literature review in Chapter Two of this thesis indicated that proxy decision-making of family members for treatment abatement requires informed, shared decision-making that is in the best interests of the patient (Curtin, 1982c). Nurses' experiences as reported in this study were that proxy decision-making was frequently not informed, not shared, and not always in the best interests of the patient.

Inadequate involvement of the nurse in the

decision-making process was almost unanimously cited by participants in this study. The previous transcript excerpt from P7 implies that she had no input into a decision that put the doctors "in this guilt free zone". To further illustrate:

P1: I think the one particular child that a lot of the staff felt very angry towards the medical staff, . . . was that it seemed that they weren't able to get a really clear picture of what was, you know, of what the ethical situation was, and the ethics committee was vacillating about what to do with this child, whether they should take him off the ventilator, and there were also family problems associated with it, and I guess as a bedside nurse you never really got to hear, it was just sort of coffee room talk or whatever, but you know we never really got an idea of exactly why we had to keep looking after this child and why they couldn't make this decision. And I think it really would have helped us to know, I think it really would have helped if the [physician] had you know come to the nurses and said, "I think this and this is what's going on", because nothing was really written in the chart and I think that if you have that kind of information, it's easier to deal with it.

P4: That's another thing, about finding out about where we're going with the treatment, I find a lot of times, one thing I wanted to mention is that a lot of times we don't, we're not involved unless we ask. Like they've gone off and talked to the family, then you don't see them for two hours, I don't know what the hell they've told them, unless I ask the family, and a lot of times they're too upset to talk about it or they don't, it doesn't quite sink in because they are so stressed out. And I think there should be more communication with the medical staff and the nurses.

Anger and frustration with the physicians were emotions frequently reported by the participants, and probably reflected nurses' feelings of powerlessness. The powerlessness of nurses as decision-makers in health care has long been recognized, and probably reflects the strongly entrenched social status differences between physicians and nurses (Ashley, 1976; Engelhardt, 1985; Millar, 1981). Nurses were left to deal with what they saw as decisions poorly made by physicians, which placed them in a conflict between their duties to the patient and family and their obligations to the physician and the institution.

Despite nurses' feelings of powerlessness, there was some acknowledgement that the physicians themselves did not find the decision-making process easy. For example:

P2: So I, sometimes I think we as nurses, it's easy for us to say, they should never keep this person alive, why are we doing this, but it's, I think we'd feel a lot different if it was actually our decision to make because it really is very nebulous and there's no clear-cut answers, there's nothing, it's something that's very individual and you have to talk with all parties and know all parties involved before you can make any kinds of those decisions and it's easy for us to say when we're not the ones who are responsible, but it's also frustrating that we have so little input into what happens.

I: So there's two sides of that, it makes it easier but it also makes it more frustrating?

P2: Yeah.

P3: And I think that's really hard when a lot of people, when the nurses, and staff, I mean you know all the medical staff, think gee the chances are pretty rough, there's a slim chance, I mean we do

have to go forward. It happens a lot I think. But there's really no choice, I suppose the patient is, I think what I often say to people in that situation where it's been a long time is that just telling them it's awful waiting, we're just waiting and it's really hard.

Nurses' ethical perspectives were that they were often not involved in the decision-making process in terms of treatment abatement. This usually resulted in feelings of anger and frustration with physicians. Some participants tempered their feelings with the acknowledgement that the physicians were attempting to make decisions in 'grey areas' of probabilities. As was discussed in Chapter One, these 'grey areas' are probably reflective of the current uncertainty in the medical community as to establishment of criteria for the application of technology (Cassell, 1986; Elovitz, 1981; Fineberg & Hiatt, 1979; Jackson, 1984; Russell, 1983; Thibault et al., 1980).

Given the variety of medical services involved in the critically ill patient's care and the lack of criteria for the application of technology, nurses described a fragmentary approach to team decision-making. In a transcript cited earlier, P1 spoke of an ethics committee trying to make decisions

about a child without communicating with the nurses at the bedside. P7 spoke of the young man with leukemia who was 'allowed to die' while still fully ventilated, and receiving antibiotics but on whom no bloodwork was to be done. A further example of a fragmentary approach is as follows:

P8: . . . not too long ago, I came on and was assigned to a woman who, well, you know, multi-system failure, she was dying, and again she was ventilated and she had, you know, 2 or 3 drips [inotropic infusions], and it was clear that the woman was not gonna make it and she was young, but you know, there really was no hope and I think what made me really angry about this situation is that they'd really put off making her a No Code [no resuscitation], so when I came on in the morning, you know, I called and asked the Assistant Head Nurses to get it clarified, and this woman's [blood] pressure had been sitting at 50 just all night, so there was, I mean if she was still a code in my mind she should've been, they should've been in that room first thing in the morning cuz she was probably one of the sickest patients in the unit but for whatever reason, well it was the week-end for one thing, so Dr. A wasn't there and there was

someone covering, but Dr. B who was covering, he's usually quite reasonable, but I don't to this day understand why they procrastinated so long. So, and again, what was really frustrating about this situation was we were doing I think hourly blood gases, or hourly chemstrips and blood gases and then we were using the formula to replace her bicarbs cuz she was so acidotic so every hour I was having to do these kinds of things plus, you know, make up IV bags, administer antibiotics which in my mind wasn't doing any good, and again, that really detracted from the kind of basic things that she needed like mouth care, you know, eye care, just turning her, but, and she was also strict isolation so that, getting to go into the room is harder as well, so I guess, so what happened was she arrested and I just hit the call button, not really intending to do anything major but they came immediately and someone dragged the cart in, and as soon as they came into the room, they said, "Don't do anything", you know, so and that just made me so angry that, why couldn't they have come in the morning and just clarified that.

I: So it was kind of a no decision until she arrested?

P8: That's right, and you know, there was this friend of hers who was outside most of the morning and he, well we brought him in as much as we possibly could, but, and so I guess I felt like I know we're supposed to go through the Assistant Head Nurses but looking at that situation I would've just gone, and I almost went to [another physician] and had him come into the room and assess the patient and make that decision, and I regret not doing that, you know when you're not getting anywhere that way.

Team decision-making as described by the nurses in this study frequently centered on the resuscitation status of the patient. The previous transcript from P8 illustrates that resuscitation was at times the only concrete decision made by the team, and was frequently made in the context of inconsistent approaches to other treatment measures by the staff. The next transcript further explores this point:

P4: . . . right now [this physician] does not, what did he say, we had a big discussion on No Code [order for no resuscitation], what No Code means, and our interpretation of No Code is totally different than his interpretation of No Code. He's figured No Code is no resuscitation; we figured,

usually the way we dealt with a No Code was you stopped all treatment, you just did supportive treatment, kept the patient comfortable and that was it. He was not that, he continued on giving all the full treatment, the antibiotics and that, but if his patient arrested then he wouldn't do anything. Well, I mean, God, that can go on for days, and days.

Decisions to pursue resuscitation were also described as sometimes difficult for the nurses involved to understand. To illustrate:

P2: I think this happened more in arrest situations where you'd gone to really your maximum time limit and you'd had no positive response or maybe they went into some kind of rhythm for two minutes out of the last hour kind of thing, but you were really we're looking at fixed dilated pupils here and a real corpse, and then they'd say, Oh well, let's try this and be damned if it didn't work, and so then you keep somebody alive for an extra, say maybe they last for six hours or something like that before they arrest again, but it's sort of a needless activity, really, you know. Like let's be a little reasonable here and when the time is up, the time is up and it's no

time to play around and create a chronic ICU type of patient off of somebody that should have gone to the great ICU in the sky kind of thing, you know, just for the sake of trying something.

"Just for the sake of trying something" recalls Cassell's (1986) warning that critical care units have become a self-perpetuating technology for resuscitation and maintenance of cardiopulmonary renal function. Inconsistent approaches to treatment decisions (e.g., deciding not to resuscitate the patient but continuing with full ventilation and hemodynamic support) may reflect incomplete institutional policies and procedures (Alspach, 1985; Evans & Brody, 1985; Yarling & McElmurray, 1983).

To summarize, a major emphasis in nurses' ethical perspectives on the theme of senselessness was concern about a senseless decision-making process. A senseless decision-making process was described in terms of inadequate involvement of the patient, inadequate involvement of the family, inadequate involvement of the nurse, and fragmentary team decision-making. Inadequate involvement of the patient took place in the context of sometimes questionable presumptions of patient incompetence. Inadequate involvement of family members was described by nurses in terms of partial,

poorly presented, or misunderstood information. Nurses saw family members as sometimes unable to represent the best interests of the patient because of their confusion with information presented to them from a variety of medical services and their confusion with the ambivalent actions of the health care team members. Inadequate involvement of the nurse in decision-making was frequently cited, and entailed feelings of anger and frustration with physicians, although some participants acknowledged physicians' difficulties in making decisions in 'grey areas' of probabilities. Fragmentary team decision-making as described by the nurses in this study frequently centered around decisions involving the resuscitation status of the patient. Throughout nurses' descriptions were ethical dilemmas for the nurse that arose out of conflicts between rights, duties, obligations or ethical principles.

Returning to the literature at this point, it would appear that nurses experienced a paradox in terms of what they thought should take place in a critical care setting and what they actually experienced. This paradox can be viewed in terms of Festinger's (1957) theory of cognitive dissonance. Cognitive dissonance is conceptualized by Festinger as an inconsistency, or

'nonfitting' relations among cognitive elements, that results in psychological discomfort. The nonfitting relations among cognitive elements would appear to be nurses' ethical perspectives that the process of decision-making was senseless, despite their belief that decision-making in critical care would objectively address patients' responses to illness, injury and treatment (Holloway, 1984; Hudak, Gallo & Lohr, 1986; Kinney, 1981).

Nurses' ethical perspectives of a senseless decision-making process often involved expressions of anger and frustration, which probably reflected the psychological discomfort they were experiencing in terms of dissonance (Festinger, 1957). R. Lamb's (1985) study has portrayed nurses experiencing extreme discomfort, or dissonance, when they saw themselves as unable to follow through on their moral choices. Wilkinson's (1985) study warned of the distress experienced by nurses when their moral choices were unable to be translated into moral action. Within this study, nurses' discomfort with their perspectives of a senseless decision-making process implies that the moral choices made by nurses in the situations they experienced were often unable to be carried through in moral action. For example, in the transcript excerpt

cited earlier from P8, her moral choice would have been to make her dying patient comfortable and allow the friend to remain with the patient. Instead, P8 was put in the position of doing hourly blood gases, mixing intravenous solutions, and in general carrying out the application of intense technology.

Furthermore, a senseless decision-making process as described by nurses in this study involved poorly informed patients and families, lack of involvement of the nurse, and fragmentary team decision-making. This process fails to come close to the reasoned, carefully planned team approach called for in the ethical and nursing literature (Aroskar, 1985; Curtin, 1978; Davis, A., 1982; Halloran, 1982; Kemp, 1985; Lumpp, 1979; Penticuff, 1982; Pinch, 1985; Prato, 1981; Thompson & Thompson, 1978).

Influences on a Senseless Decision-Making Process.

Nurses' ethical perspectives of a senseless decision-making process were described as being affected by the cultural background of the patient and family, as well as the legal climate of the patient care situation. The cultural background of the patient and family was described by some nurses as making it difficult to comprehend family members' decision-making. Culture was interpreted by nurses as

including not only the ethnic background of the patient and family, but also the values and beliefs of that patient and family that may have been different from that of the nurse. To illustrate:

P4: . . . we had a patient who was burned and that was his belief and his mother's belief [Christian Scientist], . . . my God we've done everything for this guy, but they had a hard time dealing with that and this guy was burned and he ended up having to go for a coli [cholecystectomy] too and we had to work on her for over a day to get the mother to sign the consent form so we could do this on this guy because he would have, with his burns and everything else, he would have got septic from it [the cholecystitis] and he would have died. But it was very difficult for us to talk her into it and it was a real dilemma for her and for us because this guy was going to die unless, he's going to die unless we do it. And she'd say, well can you guarantee he won't die if we don't do it, and we had to go, well, no. But anyways . . . he made it through but we did do the coli. But, you know, it's two strong beliefs fighting against each other, but I can see how it would be hard for some people that have never, I guess it's their

religious beliefs and that's all they see.

I: That's right, yeah. It puts you in a very difficult position then, doesn't it?

P4: Yes. Or anybody's religious beliefs, I guess I find, I guess a lot of people have a hard time, or I have a hard time dealing with a lot of people's religious beliefs because I mean I don't really go to church or anything like that . . .

Nurses thus described difficulty in understanding the decision-making process in the context of a variety of cultural influences. Leininger (1984) states that culture forms a "blueprint for determining human decision making and actions" (p. 42). Leininger further notes that a "serious cultural lag exists in nursing as nurses are expected to know, understand and work effectively with people of diverse cultures, and yet have received virtually no preparation in transcultural issues" (p. 42). The ethical perspectives of nurses in terms of family decision-making in this study reflect such a cultural lag.

The legal climate of the patient care situation also shed uncertainty on nurses' ethical perspectives on decision-making. In the next two transcript excerpts, P4 explores these implications in terms of

criminal cases, negligence, and an overall uncertainty of her position in the law.

P4: And the legal ones, I haven't, you know you see a few of them or you see the ones from the jail or something like that, someone's tried to knock somebody off, car accidents or something like that where there's criminal negligence involved, and whatnot, but I don't understand why we have to, if they're going to die, why we have to keep them alive a few days longer because it's a court case. I've never quite figured that one out.

P4: [re negligence] And it's pretty touchy, people are really walking on, you know, people are really uptight, everybody else is bending over backwards to try to make this right, and that's where I see it, after that happens. You see the doctors being with, letting the family know exactly what's going on and all the time, and consulting on the next course of treatment and stuff like that, and sometimes I think, "my God, this should happen more often, maybe they'd do it more often", you know, a lot of things are done when people don't know why they're being done, like that, and all of a sudden they're off to get a CT [Computerized

Axial Tomography] scan and nobody knows why. You know, the family doesn't know why, it's just decided and I think a lot of times it should be, "well, we're going to do this because" and I find that that gets done more if there's a legal issue arising.

I: That's an interesting point.

P4: Even, I guess people are really afraid of the court system itself because even, while me I don't know that much about it, but even if the family is threatening to sue, I'm thinking, "my God, they're way off base, there's no way" but maybe something could become of it, I don't know.

Given the legal uncertainty described in Chapter Two in terms of treatment abatement issues, it is not surprising to hear statements such as "people are really afraid of the court system itself". The Law Reform Commission of Canada (1982) has warned that the current uncertain state of the law will have adverse effects on health care practices. Within this study, the legal climate was described by nurses as further confounding an already senseless decision-making process.

Experiences of Patients and Families as Senseless.

A second concern of nurses within the theme of

senselessness was that what was being experienced by patients and families was senseless. In particular, nurses saw the suffering that patients and family members experienced as senseless. Nurses' expressions of this concern included statements such as "no purpose" or "what's the point". To illustrate:

P7: . . . well they say that our unit has a 25% mortality rate but I'm positive that it's a lot higher than that, it's probably almost 50% mortality rate of the people that come, actually come in. And of those that go home, probably 25% die exactly in the unit but probably 25% that make it out die within the next year. When you asked me to talk about dying patients it was, I don't know, it was really hard to . . . dying patients, they're all dying, they come in and they're all dying. You know, the ones that are so vivid to your mind are the leukemics that we get, that by the time they reach our unit they don't make it out. One in, I've been there for 2-1/2 years, we've had over 10 leukemics, and probably I've seen one, and then we've got one now that might get out of the unit but the rest usually go through the full bleed-out procedure and dying, . . .

The excerpt from P7 further illustrates the

inconsistency between what nurses believed would take place in critical care, and what actually happens ("they're all dying").

A major facet of nurses' ethical perspectives of senselessness was a concern about the loss of patient dignity. The following transcripts portray these concerns.

P7: . . . I don't know, it just seems like there's no dignity at all, there's no, the patient isn't allowed to die, you know, you have to try all these new antibiotics, even down, it sounds bizarre, but even down to the point where some antibiotics will give people papules, and this perfectly normal person now is coated in zits, and you know, it's like another antibiotic that they've added that doesn't work but the result is sort of working and you know that it's not, the person's going to die anyway, but now you've given them this skin rash and they look disgusting, and the family comes in and goes, "What did you do to them?", you know, or "Do patients always get skin problems when they come into ICU?" "No, it's the antibiotics", well, "Why?" and stuff like that, and then they've got the tube [endotracheal] in their mouth and then they've got an N.G. [nasogastric tube] in their

nose and then they get scleral edema from the high PEEP [Positive End Expiratory Pressure; a ventilator mode] so that they're grossly deformed, and they just sort of, I don't know, they turn into, it's not human anymore.

P2: I mean, when, I remember times when doctors would come on rounds and they'd be seeing a patient who [was], you know the term 'lights on and no one's home', they may not be unconscious but they're not here, and you know they'd just not really have that much respect for them as far as they'd want to show the residents and the interns something and they'd whip down the sheets and the patient would be lying there stark naked and then they'd go on and start talking, and so you'd cover them back up again and they'd whip the sheets back down again and things like that. And so obviously there's no dignity in that and there's, I don't know, some of the things that we do to people there's no dignity in either and even if patients do get out of the [hospital], do get out of ICU, a lot of them their chances of leaving the hospital are fairly slim, so you sort of wonder is it really all worth it at that point too, . . .

Loss of dignity, then, involved a change in physical appearance that left patients looking "grossly deformed" and "not human". Loss of dignity also involved loss of the ability to respond to others ('lights on and no one's home') and often resulted in actions by others such as "whipping the sheets back" that indicated a loss of respect. Loss of respect for patients thus included a loss of privacy. Given that these patients were defined by nurses as dying, loss of dignity was particularly emphasized as senseless. The notion of death with dignity explored in Chapter Two means that the individual has the right to make sense of and choices in their own dying process, and at the least the right to be valued and respected. Nurses' experiences were that this was often not the case. This presented an ethical dilemma to nurses because they were unable to uphold the ethical principle of autonomy, or respect for persons.

Closely related to the concern for loss of patient dignity were concerns about the quality of the patient's life. P1 spoke in a transcript presented at the outset of this Chapter of a "complete lack of any sort of sensory input or any enjoyment", and the lack of interpersonal relationships. Most other participants spoke of loss of quality of life in terms

of the senselessness of patient suffering. The next two transcripts illustrate nurses' concerns about the senselessness of patient suffering.

P4: . . . you're with the patient all the time and I think that's sort of forgotten along the way a lot of times, you know, we're ordering these tests and we'll try one more thing, is it going to be beneficial, we had this poor old guy that's burnt, he's got a really rotten chest and he's seventy years old, he lost his wife in the fire and he's got bilateral amputations, why are we continuing to treat this guy - he may live, which he did, but he died when, soon after he went home. I think it's pure hell to put someone through that, and that old.

I: Both the physical pain of the burn and the emotional pain of the loss.

P4: Emotional pain, he lost his wife, he's got to re-learn a lot of things, I mean, he was amputated above the elbow and one below, what's he going to do? I mean the physical deformities that he had, other than that the scars, I mean it's a long process after being burnt.

P5: . . . dying with dignity, we've got a case

in now that the chap has, he's completely debrided like from his back right down to his kneecaps and has nothing, the only thing they could do would be a hemi-pelvectomy on him, he's full of gangrene, and the family member wants everything done for him and the guy, you know, he's just, an EEG [Electroencephalogram] has been done and it's completely flat, but yet family members want to continue on with this treatment, and to do this dressing is just horrendous on the staff that has to do it and I don't care whether someone says, well he's on a flat EEG, he knows nothing of it, who am I to say, I mean, he could be sitting in the corner watching me do, you know, pack his bum . . . Patient suffering, then, is seen by nurses as physical as well as psychological, a "state of severe distress associated with events that threaten the intactness or wholeness of the person" (Cassell, 1983, p. 522). The first transcript excerpt illustrated a nurse expressing concern for the emotional pain of a patient whose loss had threatened his wholeness as a person. The second transcript excerpt indicates a presumption of suffering even with a completely unconscious patient.

Nurses' concerns about the senselessness of loss of patient dignity and the loss of quality of the

patient's life would appear to support the notion that nursing is a moral art, advocating universal values of human autonomy and dignity (Curtin, 1982b; Gadow, 1980/1983; Murphy, 1983). The foundation of the nurse-patient relationship has been described as patient-centered advocacy (Curtin, 1979; Gadow). Given that foundation, Curtin (1979) states that "[we] must - as human advocates - assist patients to find meaning or purpose in their living or in their dying" (p. 7). Nurses' ethical perspectives of senselessness indicated that nurses were concerned about the loss of meaning or purpose in their patients' experiences of prolongation of the process of dying.

Given patients in critical care settings who are frequently unconscious, the majority of the emphasis on suffering in the interviews with nurses was in terms of family suffering. The next three transcripts explore nurses' concerns about family suffering:

P3: The hardest thing I think, the really hardest thing about dying in Intensive Care is one of a medical problem, or when . . . I'm thinking of a man who was badly injured and was going to die and suffered several amputations before his inevitable death and it was really hard to be hopeful or to talk about some sort of justice, some

sort of way of her thinking about it because, of his wife thinking about it, because he was going to die and it seemed that you know, people want to know about chances, well, can I hope today, can I go home and have any hope left, and if not, then why are we still doing all these things, and when, heroic measures, when relatives aren't really about to say, I refuse, or I intervene, and say no to those kinds of measures. They can't really say as long as the medical staff give any hope and they really aren't included in the conversation.

P2: [speaking of patients following an arrest procedure] Yeah, it was really frustrating. Especially when you're looking after, you know, you have to look after the patient afterwards and they all leave and you know, you see this guy who's lying there and being ventilated and supported with all these drugs and the grief it causes for the family, when they come in and this is a person who's totally unrecognizable to them at this point, whereas when he first arrested; and if you'd left well enough alone and stopped the arrest when it should have been stopped, he still would have been recognizable to them, but by continuing on and

resuscitating them beyond the point, you know, you get somebody who's got leaky capillaries and they've got venous congestion and their head's swelled and blue and their tongue is sticking out and . . .

I: There's blood all over the place.

P2: Yeah, I mean it's not a pretty sight and you know, a lot of these little old ladies love, you know, want to see their husbands before they go or vice versa and the last thing they see is this horrible bloated thing and it's absolutely nothing like the person they've loved and lived with for the last 40 or 50 years or whatever, and I don't think that's fair. It's a terrible thing to put on the family.

P4: It's like we had this burn, that was an electrical burn, that was 3rd [third degree], like it was so deep it was almost . . . you know it was really deep, and the only thing that wasn't burnt was the soles of his feet, like you know so from here down, from his boots. They told in Emerg, they said that this guy had maybe a 5% chance of survival, so his wife said let's go for it. So for two weeks she lived through hell, and she was the

one that finally said let's quit this.

Nurses saw the uncertainty of family members in terms of what was happening to the patient ("why are we still doing all these things", "they said this guy had a 5% chance of survival") as threatening family members' intactness and wholeness. Family members were also seen to suffer as they witnessed the changes in the physical appearance of their loved one. Nurses' descriptions of the suffering of family members appears to indicate that nurses' ethical obligations to take care of family members were violated.

Furthermore, nurses' emphasis on the suffering of family members suggests that nurses extended their advocacy to the family. Nurses expressed a great deal of concern that family members had difficulty in finding meaning or purpose in their experiences of the prolongation of the process of dying of their loved one. The American Association of Critical Care Nurses' (1981) description of critical care nursing as a specialty includes a mandate for recognition and appreciation of the individual's significant social relationships. The emphasis from nurses in this study on advocacy for the family goes well beyond the acknowledged mandate.

Influences on Nurses' Perspectives of Experiences
of Patients and Families as Senseless. One concern expressed by nurses within the overall theme of senselessness, then, was that what was being experienced by the patients and family members was senseless. Nurses frequently described this concern as being influenced by the context of the patient's life history, and by nurses' own identification with that life history.

The influence of the patient's life history on nurses' perspectives of senselessness is portrayed in the following transcripts:

P6: . . . of course my feelings changed depending upon whether they were an old patient, whether they were a terminal patient, in those cases I felt that they did probably have a very good life, I hope that they had had a very good life and it was fun and just ending it now so that they were out of their suffering.

P5: It depends on the situation of a patient that's coming in, say if it's a donor patient [organ transplant donor] and I hate to say it, but if it's been involved in MVA [motor vehicle accident] that it's their fault or they're directly

responsible, that I seem to more or less detach myself from the situation versus if someone comes in that's hit by a drunk driver or, you know, a situation that they're not in control of, I tend to get, I don't know, I seem to feel more for the family than the actual patient itself. We get a lot of gang beatings and whatnot and I can totally detach myself from that patient and go and deliver my care . . .

P7: If someone's coming in who's dying who's 83 and they're completely independent or they're, and you know, they're dying or they've had this horrible mishap, I think a lot of it depends on why they're dying. It's very hard to feel compassion for someone who's been drinking heavily, smoking heavily, has COPD [Chronic Obstructive Pulmonary Disease], and has diabetes. And they're coming in because they've had a cardiac arrest, or they're coming in because they're, you know, the classic is they ran out in the middle of the night to get a package of cigarettes that they had to have and they J-walked in front of the road so they get snuffed by a truck, you know, and you're looking at this person thinking, I'm really gonna have to dig

deep to find compassion for you! If you'd have stayed home and missed that one cigarette you'd be alive and we wouldn't have to be discussing your death. But the ones that come in that have been really really healthy and they come in with a bowel obstruction and then they get septic and they go down further in the tubes and you think, you know, and that's when you go through all the business of they're not being dignified and they're not, that's when you put them up in the chair and they're drooling and they're, you know, tied in the chair, and the family comes in and goes, "That's my relative?" And you're going, "Yeah, and they look great!" And you think, well, if that was my mother I would be horrified, . . .

The emotional impact of nurses' perspectives of senselessness thus appeared to have been lessened if the situation was viewed as the end of a good life, or if the situation was viewed to be the consequence of the patients' own actions. Most participants indicated that a situation involving an unexpected event that the patient was not in control of was perceived as especially senseless.

Nurses' personal identification with the patients' life history also accentuated the emotional impact of

their ethical perspectives of senselessness. To illustrate:

P1: I think my most traumatic death at Hosp. A was a little 7 or 8 year old boy who was, in fact, a very similar age to my son, so I had a real sort of personal level there, and he was knocked down by a truck, he'd been out on his bike and he was really severe, awful head injury, really quite gross, and I had to, I came on shift and you know he was just dying, they were just pumping blood into him and he was just pouring blood and his brains and tissues and to see all that coming out, and it was really really quite awful and I think that's really the most upsetting death I've ever had to be around. I really felt quite nauseated by the lack of purpose to it, somehow accidental death, and it was somewhat his age group - I could really relate to that, it really got me close to home. I think that's something else that makes it really hard is when it's someone in your age group or they remind you of somebody that's really close to home. I think that's what bothers us, when you can really relate to them and you think that that could have been me . . . 'But for the grace of God there go I'.

P6: If they were a patient who was approximately around my age, you know, I knew what they were going through, I could relate to their space in life and [it was worse].

P3: I think the time that I remember . . . most vividly is on Christmas morning when I was missing my folks very much, 3,000 miles away, and a patient who had been sick all night, at 7:30 in the morning took a dramatic turn, and I had to phone the family. I couldn't face them because of my own grief, and my imagination about how awful this must be . . .

From the previous transcript excerpts, then, it can be seen that nurses found the senselessness of what was experienced by some patients and families was "close to home". Nurses used terms such as "traumatic" and "awful" when they identified with the life history of the patients or families.

Nurses' Activities as Senseless. A third concern described by nurses was that the activities they found themselves involved in to implement the treatment regime were seen as senseless. For example, in a previous transcript excerpt, P8 spoke of doing hourly bloodwork and mixing intravenous infusions, which took

away from the basic care needs of her patient, such as mouth care. Activities to implement the treatment regime were seen as senseless primarily because the nurses defined their patients as dying. The next two transcript excerpts elaborate on this perspective:

P2: . . . I remembered how frustrating it can be and just the feelings of hopelessness and why am I even here because half of what I'm doing isn't going to make any difference anyway.

P1: . . . It gave you a real sense of, sort of, you knew it was important to care well for their bodies somehow and yet it really was sort of self-defeating and I think in yourself you felt as if you weren't really doing anything really constructive or really positive.

Senseless activities that the nurses found themselves involved in, then, were described in terms of "hopelessness" and "self-defeating". As mentioned earlier in this Chapter, P1 described her perspectives as "rows of patients going nowhere", and P4 stated ". . . and I think we're looking after a lot of people that are dying and I think it's fruitless . . .".

Together, these accounts portray a paradox in terms of what nurses think they should be doing in a critical

care setting and what they are actually involved in. As was indicated in Chapter One, critical care nursing has been defined as "the nursing of people undergoing life-threatening physiologic crises" (Holloway, 1984, p. 1) with an emphasis placed on the nurse's decision-making skills to intervene in the patient's responses to illness, injury and treatment (Holloway, 1984; Hudak, Gallo & Lohr; 1986; Kinney, 1981). As described by P6 in a later transcript excerpt, the acquisition of these decision-making skills involves considerable preparation by the nurse. Despite the supposed emphasis on helping patients through life-threatening physiological crises, nurses often described their activities with patients in terms of "fruitless", "self-defeating", "going nowhere", "hopeless", or "nonsensical". The feelings associated with these terms probably reflect nurses' experiences of dissonance (Festinger, 1957) arising from what they thought they should be doing, and from the various ethical dilemmas inherent in their experiences.

Another consideration in nurses' ethical perspectives of the senselessness of the activities they were involved in was their lack of satisfaction. Lack of satisfaction in their activities comes through in statements such as "why am I even here" and "you

weren't really doing anything really constructive or really positive". The literature reviewed in Chapter Two indicated that sources of satisfaction may be important buffers against stress and burnout (Pines & Kanner, 1982). Nurses' ethical perspectives of senselessness in this study indicated that such buffers were not always present.

Exploring this notion further, nurses also identified that activities such as doing bloodwork and mixing intravenous solutions got in the way of their delivery of basic nursing care. Activities were viewed as senseless not only because they were perceived as useless, but also because they hindered the delivery of basic care. Nurses' difficulties with the actualities of work life that take away from what they feel to be 'real' nursing have been identified in terms of role conflict (Benne & Bennis, 1959). There appeared to be at least some role conflict inherent in nurses' concerns.

Influences on Nurses' Perspectives of Their Activities as Senseless. Nurses' ethical perspectives of the activities they found themselves involved in were described as being influenced by the length of exposure the nurse had to patients experiencing prolongation of the process of dying. Length of

exposure, or longevity as a critical care nurse, was thus an important influence on nurses' perspectives of their activities as senseless. The next transcript excerpt explains this influence:

P6: When you first start down you are so enthusiastic, you finally made it to Critical Care, have this delusion that you're going to do absolutely wonderful in critical care, you go through your orientation period where you have, you know, stacks of modules that you have to read, you all of a sudden realize that you're stupider than you thought you were, there's more stuff that you really have to learn, and basically the first six months is fear, and you're also working with, you're being precepted by people who want things done exactly the way things should be done and you're not as quick, so the first six months you're absolutely terrified and once you start, somewhere between the first six months and a year in critical care you start feeling a little bit more comfortable and being able to kind of get away from the nest and being able to cope, although you know that someone's always there to help you if need be. And once you're able to start standing on your feet a little more and start seeing a little bit

more of the type of clientele that come through, then you start seeing the non-sensical things, you know, once you've seen three of four graft versus host [leukemic bone-marrow transplant rejections] or you know, three or four 90% burns that you've grafted ad infinitum and you know they're going to buy the farm, they're going to die, then you start, but it's a matter of seeing repeated cases too, I mean, your first big bad burn and your first graft versus host or your first whatever, you greet with great enthusiasm and you're going to cure the world and everything and then all of a sudden, you know that regardless of how much you flog them, you're still flogging a dead horse.

Statements from P6 such as "you start seeing the non-sensical things" and "you're still flogging a dead horse" illustrate the growing awareness of senselessness that develops over time. Prerequisite to such an awareness is the nurses' competence in the biomedical tasks she has to master ("once you're able to start standing on your feet a little more").

Finding New Meanings

Introduction. Nurses' ethical perspectives on nursing dying patients in critical care settings centered around a theme of senselessness. Concurrent

with nurses' ethical perspectives of senselessness were their descriptions of their attempts to cope with their ethical perspectives.

Nurses' descriptions of coping with their ethical perspectives involved attempts to find new meanings by shifting their focus of action. This was described as having three dimensions. One dimension was a focus on patient comfort, a second dimension was a focus on family support, and a third dimension was a focus on each nurses' personal philosophy.

Focus on Patient Comfort. Participants identified that when they first arrived as neophyte nurses in ICU they focused on becoming competent in the biomedical tasks of patient care, such as hemodynamic monitoring and ventilator management. Once they became competent in these activities, and subsequent to growing ethical perspectives of senselessness, they shifted focus to more care-oriented activities. Care-oriented activities placed emphasis on making the patient comfortable. The next transcript excerpt provides an example of how some participants described this process:

P3: I think that's how people measure their satisfaction with their job.

I: Is with how well they're able to care?

P3: Yeah, or maybe to put it as inversely proportional to what you can't do for the patients getting better, you can do for comfort and you need satisfaction out of one or the other in any day.

I: Do you see that changing over time? In your career, I mean, has that focus changed for you?

P3: Yeah it has, my introduction was so overpowering medical that it didn't, it took me a long time to develop the imagination and the forwardness to step in and say, I can, I'd rather wash your hair than get that antibiotic in on time, sort of thing. And now I know my priorities, but they'll change everyday too depending on what the weight is of the medical experience.

I: So if it's somebody in septic shock, the antibiotic is more important, so that what that means then is that you change your priorities, that everything is situationally dependent, is that it?

P3: Yeah. Depending on the patient's needs.

I: So the context of what's going on is very important as to how you implement that?

P3: Yeah, that's right, and how much time it takes to do it, and how much I believe that that's the most important thing to do. I think with every patient you do develop a different belief about

what's more important and it has to do with their, the best of their well-being, either the potential cure or the present comfort. . . . I think when I was very new there I was just boggled by the medical terminology and wanted to keep up with the staff, and the other thing is that when you're new and not known and very shy about even joking with other people because until you're professionally accepted you're not socially accepted, so that I think is one of the main reasons for not opening up your imagination and being creative, and risking sounding foolish by saying something that would be on a comfort measure and not a medical measure. I think that that's . . .

I: So you have to do that from the base of security in yourself?

P3: You do, you really do. To know that nobody's going to laugh at you because you're washing their hair and not getting their antibiotic in time, you've got a reason that you can support, . . .

The earlier transcript excerpt from P6 and this excerpt from P3 both indicate that nurses' initial introduction to critical care was focused on mastering the knowledge and skills necessary for safe practice in

the nursing specialty. Subsequent to growing perspectives of senselessness and increasing confidence in their abilities, nurses described a shift of focus to patient comfort. Some nurses saw the focus on patient comfort as always having been important to them.

Regardless of how they saw the process of focusing on patient comfort evolving in their career as critical care nurses, most participants described their focus in the following manner:

P2: . . . I guess the only thing you can do is just try and make people comfortable for whatever time they have left and try and give them some sort of dignity.

Relief of suffering and promotion of patient dignity were implicit in many nurses' accounts, and reiterate nurses' notions of themselves as patient advocates (Curtin, 1979; Gadow, 1980/1983; Murphy, 1983).

Given nurses' ethical perspectives of the senselessness of their activities vis-a-vis in treatment regimes, a focus on patient comfort helped nurses to find some purpose in otherwise "self-defeating" activities. P3's statement that "you need satisfaction" illustrates that a focus on patient comfort helped nurses to feel some satisfaction in

making the patient comfortable. A focus on patient comfort probably also helped to relieve nurses' experiences of their ethical dilemmas.

Influences on Nurses' Focus on Patient Comfort. A significant influence described by nurses in their accounts of their focus on patient comfort was analgesia. Nurses' use of analgesia carried with it significant implications in terms of nurses' relationships with the physicians. Many participants stated that they felt strongly that liberal analgesia was a means to promote patient comfort. Many participants also stated that their use of liberal analgesia often brought them in conflict with medical treatment goals. The next transcript portrays this conflict.

P4: Geez, I get so-o mad at that, and the burn patients, hey, I give 80 mgm morphine when I give a burn bath, and they're yelling at me cuz the pressure's falling down, and I say, fine, put them on something to keep the pressure, I mean it'll come back up again, the patient's fine. I really believe that people should be, I mean if they're intubated and they're ventilated and we are not going to extubate them, so what if he's not triggering that damn ventilator, let him out of his

misery. There's no, there's nothing, I hate seeing somebody trying to scream around the ETT [Endo-Tracheal Tube], and I've, you know, I just grab them and pull them in and I say look at this, and I just give them more and, you know, it's like they order like 5-10 of morphine or 2-4 morphine prn, well I just, I take it right literally every unit apart and I'll chart it that way, even though I've given 10 at a time, I mean, I, that's the way, I don't know, I just don't like, we've had a lot of arguments about morphine and ativan and valium and how to give it and I put myself in that situation, I'd like to be in never-never land, thank you very much.

The transcript from P4 also portrays the ethical dilemma she experiences between her duty to her patients to protect them from pain, and her obligation to the physicians to carry out a treatment regime.

Tempering nurses' accounts that liberal analgesia enhanced their focus on patient comfort were some expressions that too much analgesia might interfere with nurses' abilities to assess their patients. The next transcript gives evidence of this concern:

P3: But, it's difficult, you just want to, because so many people are sedated a little bit and

sometimes a lot in Intensive Care, you expect people to be not thinking about stuff and even when someone's drowsy and most of the time her eyes are closed, it's really, I like to wake people up as much as they can be and find out how much pain they've got, how difficult their situation is, and then start again, I mean, like almost every shift, to see how comfortable they can be.

In this excerpt, P3 continued to believe that analgesia was important, but provided patients with the opportunity to "wake up" to find out "how difficult" their situations were.

A second influence on nurses' focus on patient comfort was nurses' inability to communicate with most of their patients. The resultant lack of feedback from patients meant that nurses described their difficulty in trying to imagine the patient as a person. To illustrate:

P6: Narcotized is one aspect of it but a lot of times with the illnesses that we see them with in the unit, they are very neurologically depressed, whether they have some metabolic disease process or whether a head injury, and you really don't get to know them at all because they just lay there like a lump, or they are very confused, even if the

patient is totally with it and oriented which rarely do we ever see them like that, but even if they were, then you can't get to know the patient because for one thing they have the tubes in their mouth, the endotracheal tube, so they can't communicate, they're very frustrated with their illness if they happen to be awake so that they, oftentimes the patient will project their anger and fear and everything, they'll lash out at the nurses, so sometimes you get the impression of this individual being a terribly foul old person when in reality they may be absolutely the greatest thing since sliced bread.

Not knowing the patient as a person was described by nurses as making it more difficult for them to individualize their care. A further ramification of not knowing the patient as a person is presented in the next transcript excerpt:

P3: I always feel like that's the issue, that there's a lot that you do with the patient in ICU to prepare for their own death, but it's a different kind, it's a one-way conversation often, and touch and comfort and talking about it but in a one-way situation it's difficult to deal with, I think, if someone is dying. I think that often

even if that person can possibly hear it's a lot easier to speak to the relatives and allow yourself with them because you have to prepare for it as well at this time.

I: So the staff themselves have to prepare for it.

P3: Yes, in a way.

I: By allying with the family, that helps.

P3: That's right . . .

A notion that arose from P3 and one other participant was that the inability to know their patients as persons made it difficult for nurses to prepare for the patient's impending death. Most participants indicated that they depended on family members to help them get to know their patients as persons.

Focus on Support of the Family. A second, parallel, shift of focus was towards support of the family. This focus was emphasized repeatedly through the transcripts with every participant. To illustrate:

P1: And certainly I know that if I was going to be on all week I'd say, "well, I'll have that person again", because I think it's . . . and I think even though the situation is somewhat depressing I think a really good rapport with the family can make up for an awful lot. And you know

I think that can make you feel that you are doing something, if you're not doing too much physically for that person, that they're not going anywhere.

I: So even if you don't see the patient going somewhere, you see that you can help the family somewhat.

P1: Yes, if you can be of help to the family, and I think as the primary caregiver you can be very important to the family and very often the doctors are very very rushed and there a lot of different doctors, interns, residents, consultants around and I think they really want one person to be able to talk to them and get consistent answers, you know, a trust from. I know that certainly in the pediatric setting that they really take, they really sort of seem to latch on to one nurse as they say, in really stressed situations, I think they take great comfort from gaining trust in one person and having that person look after their child.

I: Right.

P1: Because it is quite an element of trust leaving someone you really love in a person's, an ICU's, hands for 24 hours, and you've got to feel really good about it. And make the conclusions

that they can trust you and that they can relate to you, talk to you.

I: And so you felt like, when you were in those situations, you had more of a sense of purpose being with the family.

P1: Yeah, I think you do. And even if they die, then you still have a sense of completeness, that you've been able to sort of go through the process with them, and be there at the end.

P5: . . . you know, I just, the family plays a really important part with me because I just, I've never experienced a family member of mine dying and I just, I don't know what it would be like although I've had friends that their family members have passed away. But the patient really sometimes never enters my mind, who has died, it's more the family member that is in my mind, and a lot of times, well I lied probably the first time when I said I hadn't really brought my work home, I did once or twice with a lady that kept coming in, we had her husband in for six months and [he] had continued to deteriorate and finally passed away and of course she'd sit at his bedside for 8 hours and we just couldn't get her away and social

services came in and the whole bit. And he died, and you know, I think she was just all cried out and I'm sure everyone of us just sat and kinda went "ohhh" and I thought of her for a good many nights after because that was all her life the last six months, that was all she geared herself for, and so, it's more family members I'd say that I feel for than the patients.

I: Yeah. That's actually been coming up a great deal.

P5: Yeah. It's just so very hard to deal with and they're so stressed out that they just, you know, you just, even when you get medical family members that come in and are so out of tune, we had a [patient] whose father was a doctor and was completely oblivious to what was going on. He had no, just as though, as though he was a mechanic, like he'd never been in medicine.

I: So you can't make assumptions just because of his background?

P5: No. So again I would certainly say that it's the family that would be my concern.

Most participants described a sense of purpose, or completeness, when they felt they were able to focus on the family. The statement from P5 that "it's the

family that would be my concern" points out the strength of this shift of focus as nurses attempted to find new meanings.

Participants in this study emphasized their focus on the family unanimously in terms of support. The next transcript from P6 describes her notion of support of family members, and is congruent with other participants' descriptions:

I: I think, just following along your train of thought there then, the other area that I wanted to explore before I got into my overall interpretations was that you really, I think, put a strong emphasis on, that the family really do rely on you for emotional support.

P6: Very much, very much Everything, they need everything. They need, again it has to do with the one individual, and when I'm talking about the individual in this case I'm meaning family, again the amount of support that they require again is dependent upon what their coping mechanisms are and how they're to deal with it and also on what their past experience is, have been, to help them through this, but generally families depend on you for everything, absolutely everything, emotional support, information and

clarification of what the doctor has told them, if they happen to have told them anything at all, lots of anatomy and physiology, basic anatomy and physiology, statistics on what probable outcomes are, they also rely on you, actually they don't rely on you but you find yourself almost in a mother or a parent type of role, setting up rules and regulations, some families they just, you can see them, they're destroying themselves because all they're doing is hanging around the unit all the time, they're not eating, and you see the family dynamics in some cases just totally fall apart and you have to sit down with them and say, Okay, you know, you've gotta go home, you've gotta have a shower, you've gotta have something to eat and I'm not letting you in until 2 o'clock, and if I look out there and you're not and you're still there, then you're not gonna be let in until 3 o'clock, so they're, they definitely need limitations, and I'm not talking about all families, a lot of the families are, and initially they balk at it, I mean as any teenager would balk at it, but then they come back and I've gotten numerous hugs from saying thanks, you knew exactly what I needed, and they feel 100% better because, and I found that I would,

I always used to tell them, the ones that were like that, is that I have steel-toed boots and if need be I'll give you a swift kick, and because, oftentimes it was in families who you knew that the patient was going to die, you just knew it, and you knew that they needed everything in their inner self to cope with it and you knew, I knew that if I didn't get them, make sure that they were rested, if I didn't make sure that they were eating, that they were just not going to be able to cope with the situation, with the inevitable situation, and the nurses role also is to maintain a sense of reality.

Support of families, then, meant helping them to know what to expect and helping them to care for themselves. Nurses' focus on helping the family to know what to expect and helping them to care for themselves can be seen to be inherent in nurses' notions of themselves as advocates for the family.

Support also meant helping family members to prepare for the patient's eventual death, in particular helping family members to deal with their hope. The previous transcript from P6 continues:

P6: You have to feed them hope, sometimes when there's not any hope, but feed them just a little

tiny bit of hope just so they have something to grasp onto until it's time for you to kind of start bringing it down because a lot of people can't accept the fact that the patient is going to die until the right time, so you just have to feed them a little bit of hope until you see that they're ready to get the information and find out what the inevitable outcome is going to be and then you can start getting them through.

I: So it's a really, it's a process that you have to really judge carefully over time as you watch them?

P6: Yeah.

The majority of participants emphasized a process of helping the family with a here and now reality, and not bolstering what nurses saw as false hope. To illustrate:

I: So it was hard to see the parents not knowing what they faced in the future and that you felt you had a better idea of what that might be than they did possibly.

P1: Yes. I think a lot of the times until you've been in a hospital, most people haven't seen comatose or unconscious people and they have very little notion, they haven't had personal experience

with a handicapped person, they have no idea, they sort of have this fantasy that these people are suddenly going to wake up and they are just going to be the way they were before. And yet we know that that isn't so, but you can't destroy their denial at that point and you can't just destroy that hope either. You just sort of have to do nothing, even though it's just a matter of time. They will be gradually faced with the reality.

I: Did that feel like that was a difficult position to be in?

Pl: I think it was hard in that you're . . . you know well they'd say, "when are they going to wake up, when are we going to see him open his eyes" and whatever. You didn't want to reinforce their denial and say, "Oh well, he is going to wake up and he is going to be fine", but at the same time you knew that's very important for them at that point in time and to completely destroy it . . . so I think, I know the route that I would choose would be you know not to really reinforce those really optimistic decisions and just say, "well it's just going to be a day by day process and we'll just have to see what he's going to regain slowly", which function, and explain if any function comes

back or you know if he's beginning to withdraw to pain or he's beginning to do this and that when we check him. I think just sort of continually just dwelling into the factual examinations of the moment.

P4: Well, you know, they're always, they phone and they ask how are they doing and they're always, you know, at least five times a day and, you know, they're always visiting quite often and that's fine but there's always, you know, How are they doing, is there any improvement, and the thing that I find hard is I, just to say that maybe something has improved, and all of a sudden, my god, they just pull on that, they grasp on that and then it's so devastating if something happens. So a lot of times I find that even though he may have improved a little bit, I just sort of play it down and I don't even say, you know, they're going through such ups and downs anyways that . . . When it's hard is when they have improved a little bit or sometimes you know, well you've seen it too, I mean, some patient is on death's door and all of a sudden they improve and you know it's just the final burst before the crash.

I: That's right, yeah, that's very true.

P4: And that's when I find it really hard to tell them, "Yeah, they have improved", but how do you say, "But they probably, something is gonna happen." But I just, I sort of say basically, "Yeah, they have improved but anything still could happen, they still could die".

Support of families, then, meant focusing on reality to help prepare them for their loved one's death.

Focusing on reality to prepare family members for the patient's impending death is congruent with notions of support in the nursing literature. Mishel and Braden (1987) state that "a major function of social support is to provide the opportunity to the person to clarify his or her situation through discussion and interaction with others" (p. 55). Nurses' descriptions of "feeding family members a little bit of hope until you see that they are ready", and "playing down" temporary improvements in the patients' condition were seen as attempts to help family members clarify their situation. The statement from P1 that "you can't destroy their denial at that point and you can't just destroy that hope either" affirms Gadow's (1985) position that "the truth cannot be presented in a 'finished' form to patients, but requires their

participation in constituting it . . ." (p. 38). The focus on support of the family described by nurses in this study illustrates that nurses were sensitive to the need to listen to and involve the family in the construction of truth, or reality.

One participant offered the following elaboration on her focus on support of families in relation to hope:

I: I think in speaking of it being difficult you said that, it's difficult because you need to approach people and give them a balanced picture that gives them room for hope but also an understanding of the seriousness so they can decide and come back and just engage them in "this is what's happening", . . . I guess maybe my question is, can you tell me more about what that "balanced picture" is about?

P3: The balance of hope on one side and . . .

I: Seriousness on the other.

P3: Yeah. It's difficult because in some ways there is no hope, for this situation to go any further and . . . but people do go on, and sort of trying to substitute things that are just as important for that person, it's difficult to talk about that as a balance but, I believe it's our

nature to substitute things that are important and as one bleeds something else has to happen, and that's where hope just comes and sort of takes care of us.

I: Hope is the thing that just balances it?

. . . .

P3: Hope for just that we have to go on and something else will help us out.

To summarize, P3 identified two forms of hope as she supported families; hope that the family members would find their way to carry on after their loved one was gone as well as hope that the patient might be better. The latter form of hope was viewed by most nurses as something to be handled carefully; not to be inflated, but also not to be taken away.

Hope has been described as being generative of action (Marcel, 1967). As such, hope has become acknowledged as necessary for individuals to cope with living or dying (Dubree & Vogelpohl, 1980; Hickey, 1986; Lange, 1978; McGee, 1984; Rideout & Montemuro, 1986; Roberts, 1978; Schneider, 1980; Stoner & Keampfer, 1985; Wright & Shontz, 1968). Hence nurses' statements in this study that hope that the patient might get better should not be taken away was important in their focus on support of family members. Hope that

family members would find their way to carry on after their loved one was gone depicts a broader notion of hope. This broader notion of hope is rooted in existentialism, and implies that the individual can hope to find some meaning, or purpose (Hickey, 1986; Miller, 1985; Taylor & Gideon, 1982; Vailliot, 1970). As described by P3, this form of hope was "hope for just that we have to go on and something else will help us out".

Influences on Nurses' Focus on Support of the Family. In describing their experiences supporting the family members of patients who were dying in critical care settings, nurses spoke of four major influences. These included the influences of nurses' development of increasing competence in their nursing practice, the cultural background of the family, nurses' workload in the patient care situation, as well as the influence of nurses' perceptions of support from others.

Shifting the focus to the family was described by most nurses as happening when they developed more technological expertise as well as more experience and confidence in dealing with patients and families. In other words, this happened as nurses developed increasing competence in their nursing practice. The next two transcripts describe how P2 and P3 saw this

focus developing over time in their career as critical care nurses:

P2: But just spending, I actually spent the odd day with the family but I spent almost the entire evening, the evening that she died with her, [family member] and you know just talking to her and helping her to get over these things and her husband was just an absolute gem through the whole thing, he was really good, but I think that was really, it was definitely hard to do and certainly when I was younger I couldn't, it was, I wouldn't have been able to go as far as I did with them and spend as much time as I could because it's just, you know, it's very emotional, it's a really difficult time and so, but it's rewarding to, you know, spend some time with them and be of some help to them because that's really what you're, who you're helping at that point is the family, the immediate family and being of some kind of support to them and offering everything that you can.

I: That's very important. . . . for what reasons do you think it would have been harder for you when you'd been younger?

P2: Because I was less, you know, as you're less mature you're just, I was certainly one that,

anyway, that really whipped out at things and I guess I just couldn't handle it, it was just too . . . strenuous, or maybe I was just afraid to cry with people. I don't know, maybe that was part of it, I was always really good at making coffee and making sure that they were sitting in the lounge and were comfortable and had, you know, and made sure that other people came to see them, like this would have been back in the Catholic Hospital where we had the nuns would come around and stay with them or the priest or whatever, there was no problem with that, they'd come anytime of the day or night, and, but we'd always make sure that they were comfortable and that the visiting sister was called and she would come in and look after the emotional and spiritual needs, but even to that degree it was really nice and I really appreciated that they were there. Certainly when I was working in City B that kind of support system was not there for the family at all and half the time they were sort of left half sitting out in the hall, in a very busy hallway, half ignored, and there was just no one there to go and talk to them half the time.

I: So in that situation, and with more experience under your belt, you found that you did

more of it yourself?

P2: Yeah, if I had the time, certainly.

P3: My fear of family has diminished radically and at this point when, well let's see, if a burn patient comes in and there's a person outside I'm much more sensitive to the immediacy of what they need, they need to be dealt with within the hour, I won't, I will probably designate, if I were working with a patient and getting him or her settled in bed and dressed and with IVs going and analgesics going, I would keep that first but I would be much more quick to involve that family, I would be much more quick to involve the family and to know that this person is going to be, I guess the overall perspective of caring, knowing who's long-term, who needs the most assistance with getting used to the situation that I'd be much more quick to letting that person come in and knowing that what I say now is going to have a lot to do with the way she or he feels about the situation, so it has developed over time, whereas before I would have avoided that, avoided me talking to that person, to know what kinds of things you need to say and what kind of position to take. I think you need role models a

lot.

I: I was going to ask you what makes the difference, like is it, like that you know that now, is that experience or training, or are you saying role models as one?

P3: Yeah, well just as the family does get used to the situation and within a week will be coming in and not crying, but asking questions about electrolytes, so does the nurse get used to the fact, get used to the situation of talking to a grieving person, and comfortable in that, and actually very involved and very grateful to be able to do that so that sometimes what you really want to do is focus on the family because it's horrible what's happened to this person and you're feeling some of that and so to do something for the relatives is really helpful.

A second influence on nurses' focus on support of the family was the cultural background of the family. Most nurses indicated that they found it more difficult to support family members from a different culture. To illustrate:

P3: It's very hard if the relatives of the person that's dying is, does not want to speak or seems very confident about it, it's difficult to

approach someone's insecurities. It can be difficult when there are cultural differences between staff and relatives and not one of them comes out as spokesperson. The staff will have to choose someone and say this is, that we'll have to choose this spokesperson. And then in a way the culture seems to be very strong when it presents itself in that way and the preparation is not, it's something that the culture has already spoken for that it works into it, they already know what they're dealing with, and they already know how they need to grieve and whether they need to be noisy or altogether or very quiet or with the person.

I: So it's quite a different process when there are different kinds of cultural variables?

P3: Yes. I think that's the interesting thing, is that it's always different, always, always different.

P6: . . . especially when you've got ethnic families who love, oftentimes you end up, they put a big wall up.

I: It's harder with different ethnic families, is it?

P6: Yeah.

Just as nurses found it more difficult to understand the decision-making process of patients and family members from a different culture, then, they also found it more difficult to support family members from a different culture. Words such as "different" and "harder" were used to describe this influence.

Nurses' experiences of workload in the patient care settings were that their involvement in tasks sometimes detracted from their ability to spend time with families. This influence is explored in the next two transcript excerpts:

P2: [re looking after an unstable patient] . . . and obviously you're really busy and you need two people there, I mean, you can't do it yourself so even, it keeps two nurses busy and there's no one to tend to the family at all, and you can send the resident out to look after them or the physician or whatever, but you have no idea what they've told them and what they understand, so . . .

I: It's much more difficult to be able to do it when the workload is such that you don't have time to stop.

P2: Yeah.

P5: And somehow if you're with a really busy patient you just don't have time to give family members the sort of emotional support that you would like and we've been busy and especially with the donor patient that's come in, you're so busy trying to get them all up to a certain level of, I guess idealism when they want to be transplanted that all they're hemodynamically what that team wants and their renal status is what that doctor wants and you've given all the antibiotics for what the orthopedics want for their bones and you're just so wrapped up with doing all this and family members are sitting there and are looking at a patient that merely has a bump on his head or has no physical signs of injury and they still see their heart beating and their chest rising and yet you have no time to kind of say, you know, sit down and explore their feelings whatsoever.

The latter transcript in particular points out how nurses' workload in the patient-care situation presented them with an ethical dilemma between their obligations to the physicians and institution to implement the treatment regime and to the family to help them "explore their feelings".

Nurses' descriptions of the influence of workload

on their ability to focus on the family recalls the emphasis on situational constraints illustrated in the ethical, stress, and moral reasoning literature presented in Chapter Two. Nurses' experiences in this study were that the situational constraints of a demanding workload to implement treatment regimes hindered their focus on support of the family.

Nurses' perceptions of support from others as an influence was emphasized repeatedly in several transcripts. The next passage indicates that support included role modeling from peers that helped the nurse to develop her own skills in dealing with family members:

P3: It helps, it really helps when you see somebody else speaking on your behalf, say if you're involved, but I mean another person just come and sit while you're working with the person outside the window and talking so you can listen and see, and listen to different situations, I think that a person in charge if nurses are new that they really should have that opportunity to sit and listen to what a charge nurse, an experienced nurse, would say to relatives, because it's very difficult to know how corny you can be or how blunt you should be, or how hopeful or hopeless

you should be, I think it's a very difficult thing, there's a real art to it and there's not that much focus in your nursing training on exactly what to say, so I just think it's something you need to develop, and experience is definitely a part of it, being afraid for a while and then going through it and realizing that you feel satisfied that you did it, and then eventually wanting to do it yourself because you could do a better job maybe and because it's your concern, incorporating it into your concern. But also realizing that the family is very important to you and helpful instead of a hindrance.

Support also meant recognition of the nurse's contribution to the patient care situation and offering her resources and choices:

Pl: I think reinforcement from your peers is really important too. If you've got an Assistant Head Nurse that's really supportive, or a Head Nurse who's saying, "well, you're doing a great job", or you know, is sensitive to your needs, or "can you handle this family again or would you like me to?" I think that element of choice is really good. And to say, "well how do you feel about having these people again?". . . I know it's not

always all that easy to be able to give people choices but I think it really helps. And the bedside nurse could cope with those situations better if she feels it's her choice, it's not being imposed on her. . . . I think the answer is just good teamwork and peer support.

Support for nurses was also described in terms of an atmosphere of positive interpersonal relations:

P3: I think it's a most dramatic thing that happens at work and the most important to me, it seems to me that the reason that I am there and the reason why I can work in a place like that is because of the coping qualities and one of them being that the relations are conducted in a really positive way with people and that they can begin to accept situations and accept someone's death and begin to create, in a way that makes me feel comfortable about it and because I've been helpful, that something positive will come out of it.

Lack of support was described in terms of other professionals being distant, not understanding, not providing the nurse with information, not understanding the nurse's position, not communicating, and not functioning as a team. The next transcript illustrates lack of support:

I: When you said no support from the upper echelon, by upper echelons did you mean people in your sort of unit management, hospital management, or . . . was there a group you had in mind, or ?

P4: Well, I was basically referring to the doctors because they're the ones with the final decision. Upper echelon, well you could start going into the nursing supervisors . . . I mean, they don't have a clue what's going on anyway the way the system is set up . . . and so I don't even take, whatever comes down from them and they don't understand what's going on anyway.

I: So the people that you're most directly involved with, upper echelon wise, are the doctors then?

P4: Yeah. Although nursing doesn't give you support anyways, they wouldn't recognize, . . . I never really talked to them, it's just a lot of the things that come down are just, just ignore it, because we're not getting the support from them anyhow.

I: Right. And I think I know what you mean by support but that's another word I'll have to be careful of in this. When you use the word 'support', what kinds of things do you mean?

P4: Umm, just that they a lot of times will just sort of you're talking, well the family is having a hard time dealing with this, don't you think somebody should talk to the, things should be more honest, why are we doing this, and you get sort of a pat on the back, well, it's alright, just cope another few days longer and it just doesn't seem right, the mesh-knit working together that there should be a situation like that.

I: So support means working together and also answering or dealing with questions and concerns you raise?

P4: Yeah. Or, even, a lot of times I find that they've talked to the family and then, God, you don't know where you're standing, you know. And then you ask the family, well, what did they say, and they said, well, they sort of said this but they're in such shock anyways a lot of times nothing sinks in, but it would be nice to know, if you knew exactly what went on, even if they don't tell you. Cuz I mean a lot of times you can't be talking to each other all the time but just write the damn thing down somewhere so you know where you're at.

I: Right. So it kind of revolves around

communicating with each other too?

P4: Yeah. There's a big lack of that as far as I can see.

In summary of nurses' accounts of the influence of support from others on their focus on support of the family the following points can be made: positive support was described in terms of (a) role modeling; (b) recognition of the nurses' contribution to the patient care situation; (c) offering nurses resources and choices; and (d) an atmosphere of positive interpersonal relations and teamwork. Lack of support was described in terms of: (a) others being distant; (b) not understanding; (c) not providing the nurse with information; (d) not understanding the nurse's position; (e) not communicating; and (f) not functioning as a team.

Nurses' accounts of the influence of support from others further validates the importance of nurses' perceptions of situational constraints in understanding how they cope with their ethical perspectives of senselessness. It has become increasingly recognized in the nursing literature that efforts towards communication and collaboration are necessary for nurses to cope with difficult patient care situations (Anderson, Pierce and Ringl, 1983; Breu, 1983; Janken,

1974; Michaëls, 1971). Nurses' experiences as reported in this study were that such support was often not present.

Focus on Personal Philosophy. A third, concurrent, focus in nurses' attempts to find new meanings was the expansion of each nurse's personal philosophy. One aspect of that expansion was experiencing and learning from people while sharing an intimate life event. To illustrate:

P1: And I think that you're very privileged to be with people at those points and times, and if you can handle it yourself and sort of be comfortable with it, that you're very lucky. I think nurses can be very lucky in those times because you're really, it's in times of need that people reach out to you and you do develop really intimate bonds with people, and I think it's that intimacy with people that makes it a really rich experience for yourself as a nurse.

Some participants emphasized the mutual sharing that they experienced with the family in terms of how it affected their personal philosophy.

P3: . . . an alliance between all of us that nature does take its course and that we can't control everything and that we're all in it and

it's, isn't it miraculous really that this is another glimpse of the way things work in the world and we're getting really close to something really special and really hard is going to happen, but very special because it's so mysterious. I think that's the neat thing about talking about it because you're never really qualified to talk about it and I think you have to be really interested in communicating that there's a proper way, that you think there is, having a philosophy of it because I don't think you could ever write down that there's a way of dealing with death because we don't know anything about death really.

Expanding their philosophy to create meaning out of caring for dying patients in a critical care setting was also intertwined with nurses' philosophy in terms of their own life.

P7: . . . you really do though, you start really appreciating life because everyone's dying.

Furthermore, participants identified that the expansion of their philosophy changed over time. Participants attributed the change both to their experiences looking after dying patients as well as general life experiences.

P4: Yeah, well I think it just makes you think a

lot more, I mean you're just sort of breezing along when you first get out, at least I was, I mean, you're finally out and working and making money, and for the first year all you're doing is you're going to work and you may bitch about work, being short-staffed and like that, but, and things did affect you, but that's as far as it went. I didn't have nearly as much deep thinking, but I don't know whether that's just because maybe as you get older you do that anyway, I don't know. But I find that I'm, I do think a lot about a lot more now than I used to, about where we're going with this patient and I think being in a critical care setting is probably, you know, pushed that on because of, you know, how many patients don't make it out, and why are we doing what we're doing? What else, just in general, about everything, like where are you going and about all the different religious beliefs and how people are so strong in their beliefs and I find that there are certain beliefs I have I guess that are very strong but there's so many variables out there and I guess you see that in nursing . . .

The expansion of each nurses' personal philosophy thus involved an emphasis on learning about life. Statements such as "you're very lucky" and "isn't it

miraculous really" indicate that a focus on personal philosophy was a source of satisfaction for some nurses as they cared for patients who were experiencing prolongation of the process of dying in a critical care setting.

Influences on Nurses' Focus on Personal Philosophy.

Nurses described their focus on their personal philosophy as being influenced by the amount of energy they felt they had for themselves. Energy for self appeared to be a product of nurses' perceptions of a variety of influences, particularly support from others. Too little energy was experienced by nurses in terms of needing to achieve emotional distance for themselves. The next transcript illustrates this need:

P6: But a lot of times in a critical care setting you really don't want to know the person, you don't want to know the person, because we are exposed to so much death and you don't, it's hard, it is hard, and if you took everything to heart you'd crack, and over the years I've seen lots of people crack, and I think the only thing that's got me through and the only thing that's gotten a lot of people through is you develop a real sick sense of humour, and you don't take things as seriously as maybe a lot of people, when it comes to the

crunch, I mean you definitely take things seriously and you don't let someone's blood pressure hang around 60 and not get upset about it, I mean you definitely treat it, but you try not to take the deaths right to heart, and once you know the, once you really start getting to know the individual you start to, sometimes start to identify with them, whether they look like your father, . . . or something reminds you of your husband, or something like that, and you don't, and it makes things really difficult because then you start to identify with what the relatives must be feeling like, and it's just too hard, so oftentimes it's, I always like to know something about the patient so that they'd be a little bit more comfortable but I didn't want to get to know the patient because I just, it was too difficult.

I: So it's a really fine balance then of having to stand back a bit to protect yourself.

P6: Yeah, yep. In fact I'd always, you know, I would always take myself as far as the family or the patient needed me to go and sometimes it was at my own detriment, but I mean that's probably the biggest crunch that they're going to have to go through in their entire lives, the families and

also the patients, I mean I was willing to take myself that step and sometimes it would take a lot to pull myself back, you know, to recover after the patient died or whatever the situation was, I mean, I would never be, it wouldn't ruin me for a month or anything, but I had you know several crying spells in the back and you know, and then it was over, you know, it was over and done with.

The need to achieve distance appears to have been a response by nurses to a significant emotional involvement in the care of the patient and family. Philosophically, some nurses expressed a need to stand back. The next two transcripts continue to illustrate this philosophy.

I: . . . when you say that you feel that you've become 'callous', what does that mean?

P5: Hardened, I guess. I'm there to deliver my direct patient care and sort of when my 12 hours are up and, change shifts, you know, give report and I'm out and I've forgotten the whole day sort of, and I think when I first started off in nursing on the burn unit I'd take someone home [think about them] and I'd think, "Holy geez, they're gonna have a long hard life, and oh-h, many more surgeries, too bad", and this and that, now it's 7:30 rolls

around and I'm gone and I really never give patients another thought when I go home. . . .

I: Is there an element of self-protection in that?

P5: I think so, yeah, you know I think if I let my feelings through I could probably think, "Oh boy, that could've been me", or "that would be awful if it was my mother or my father". . .

P7: It's like there's no dignity once they're admitted, it's like they're stripped apart, they're taken apart in pieces, and the family comes in and goes, "Well, you know, how's my son doing?" "Well, cardiology says this, neuro says this, renal says this", and this person is looking at you saying, "Well, how is my son?" Well, in different parts, he's doing, different parts are doing different things but as a person he's going to die, he's no longer going to be a person. And I've been there for 2-1/2 years now and I'm recognizing the fact that it's time to get into something else because I'm starting to, I used to have lots of compassion for these people that are dying and these families and stuff like this and you just, it eats you out if you let it get to you, and I never thought that

I would turn into one of those hardened ICU nurses, but I can see that I do in some cases, that I've totally, I will totally disassociate myself and I can give compassion to the family and I can make the patient look gorgeous and I can do that, and then I can go home and have a perfectly normal life, and that's not right. It's very difficult to come home, I suppose it's a survival mechanism that you have to do, but you know, if you thought about, if you're sitting here at the dining room table, you're having dinner with your boyfriend, husband, whatever, and you know, Well, yeah well I had this 23 year old guy who's dying, you know, I mean how to ruin a dinner. You just can't discuss, you know, you can bring certain things home, but you can't, or it would ruin your life. You would absolutely, you wouldn't have a life. And I don't know, I'm going through a real phase where I can't decide whether that's because I'm getting burnt out, that I am allowing myself to disassociate from the patient, or whether it's a survival mechanism and this is just the way it's gotta be, you know. And it's, I have to decide what is actually, you know, what I'm actually after and what it's gonna do, but . . .

I: It sounds like you've thought a lot about it.

P7: Oh, it is, it's really bothering me, really bothering me because I used to get, I still cry at work, I'll still cry and stuff like that and get, you know, some patients you relate to and some you don't. It doesn't matter what age, it's really weird.

Energy for self thus appears to have been an important influence in the process of nurses' construction of meaning. Too little energy for self was described in terms of the senselessness of caring for patients being "too hard", feeling "callous", and "allowing myself to dissociate from the patient . . . [as a survival mechanism.]"

An important feature of the last transcript from P7 was her statement that she was unable to talk about her ethical perspectives with others. Most participants commented on not having had the opportunity to discuss their ethical perspectives before. P1 spoke of feeling like a "lone voice in the wilderness".

This lack of opportunity to talk with others, be they peers or nurses' own friends or family members, has been previously identified in the Nursing '74 (1974a & b) ethical survey as well as A. Davis' (1981)

work. Nurses' concerns about their lack of opportunity to talk about their ethical perspectives further emphasizes the importance of nurses' perceptions of support from others.

Nurses' descriptions of the influence of the amount of energy they felt they had for themselves emphasizes the emotional involvement of nurses caring for dying patients reviewed in Chapter Two (Davitz & Davitz, 1975; Fenton, 1987; Field, 1984; Lamb, R., 1985; Wilkinson, 1985). Expressions of feeling "callous" and "dissociating" are reminiscent of descriptions of burnout in the nursing literature (Maslach, 1982; Pines & Kanner, 1982; Storlie, 1982).

Evolving Meanings

Given nurses' descriptions of finding new meanings as occurring over time and subject to a variety of influences, nurses experienced a circular process of evolving meanings. Therefore, individual nurses' ethical perspectives on nursing dying patients in critical care settings were not static. The next two transcripts depict how meanings evolved over time:

P6: But I, but it was almost seasonal, I could, like I only cried for a short period of time, like when I was going to work and let's say for four days or something like that, so it's kind of an

isolated incident, but I could feel every spring and every fall there was something different and I just found that I needed to get away for awhile and it wasn't that I couldn't cope, I didn't feel that I couldn't cope, and I felt that I was still doing the same sort of performance, but I just knew that I had to get away and it was every spring and every fall, and I don't know how or why it was then at all, so what I used to do is I used to book my holidays and I always used to book holidays in May and September and I would, I could feel it, maybe cuz I knew my holidays were coming and I would just feel it coming on and the only thing that got me through was thinking, "____, you go on holidays for a month in May, you go on holidays for some of the time in September", and then I'd come back and I would be totally refreshed and I would just keep on going and it would be fine.

Pl: Yeah, and I think firstly that people, I think you go through different phases in life and I think that these things come and go, it's been interesting for me to sort of have different kinds of exposures over different times and I think when you first get back into it again it's quite, you

can sort of develop these coping mechanisms and sort of ideas and you do feel pain and then getting away from it, I think I told you when I'd been up in [the surgical ICU] and I hadn't had a death for a while and then suddenly I was back in ICU [general] for a shift and there was this really sad, how all those feelings of sadness came back again, so I think that patterns can change within people.

I: I think that's an important point.

Pl: I think being away from it for a while can kind of, sort of it gets pushed to the back of your mind and then when you're exposed again, it was the same with the [patient in general ICU], you know, it just suddenly all came back again, all those feelings, and I had to sort of sit down and think about it all over again and sort of decide what it was that was painful and why I was feeling frustrated about this particular situation and so, I think it can come and go, you know, and I think different life situations certainly play a part. And you were saying that, about the amount of stress, or the lack of support or whatever, in your life, and I see that as really relevant, I think, you know, whatever life space you're in is really

important . . .

Nurses' experiences, then, were not that they always had the same meanings when nursing dying patients in critical care settings. For example, P6 found that her meaning that she "couldn't cope" was "almost seasonal", and P1 identified that moving back into an ICU setting she had to face a meaning of "sadness" "all over again." The statements from P6 that she felt "totally refreshed" coming back from holidays, and from P1 in terms of "whatever life space you're in is really important" underline the importance of energy for self in the kinds of meanings that evolved.

Summary

Theme of Senselessness

Nurses' ethical perspectives on nursing dying patients in critical care settings centered around a theme of senselessness. Senselessness was described by nurses in terms such as "fruitless", "going nowhere" and "self-defeating". Senselessness illustrated the conflicts experienced by nurses as they cared for patients undergoing prolongation of the process of dying, and was associated with feelings of anger, frustration and powerlessness. The conflicts experienced by nurses were comprised of multiple

ethical dilemmas arising out of the ethical problem of prolongation of the process of dying. Most of the dilemmas identified in the nurses' descriptions were framed in a conflict between the nurses' obligation to the physician and institution and her duties to the patient and family. The feelings experienced by nurses probably reflected their responses to the multiple ethical dilemmas they found themselves in, as well as to the dissonance (Festinger, 1957) implicit in their experiences.

The theme of senselessness was explicated by nurses in terms of three major concerns. These concerns were: (a) a senseless decision-making process; (b) experiences of patients and families that were seen by nurses as senseless; and (c) activities nurses found themselves involved in to implement treatment regimes that were seen as senseless.

A senseless decision-making process was emphasized repeatedly through the transcripts with every participant, and was described in terms of the process by which decisions were made, rather than the decisions per se. Most decisions described by nurses related to treatment abatement. Inadequate involvement of the patient, inadequate involvement of the family, inadequate involvement of the nurse, and fragmentary

team decision-making were all part of a senseless decision-making process. Nurses described their ethical perspectives of a senseless decision-making process as being influenced by the cultural background of the patient and family, as well as the legal climate of the patient care situation. In relation to these influences, nurses described their difficulty in understanding family members' decision-making in the context of a variety of cultural influences. Nurses also described an overall uncertainty of their position in the law as confounding their perspectives of an already senseless decision-making process.

Nurses also expressed concern that what was being experienced by patients and families was senseless. A major facet of nurses' ethical perspectives here was a concern about the loss of patient dignity, implicit in which were concerns about the quality of the patient's life and patient suffering. Given patients in critical care settings who are frequently unconscious, the majority of emphasis on suffering in the interviews was in terms of family suffering. Nurses described their ethical perspectives as being influenced by the context of the patient's life history, and by nurses' personal identification with that life history. The emotional impact of nurses' ethical perspectives of senselessness

appeared to have been lessened if the situation was viewed to be the consequence of the patient's own actions. Most participants indicated that a situation involving an unexpected event that the patient was not in control of was perceived as especially senseless. Nurses' personal identification with the patient's life history also accentuated the emotional impact of their ethical perspectives of senselessness.

A third concern described by nurses was that the activities they found themselves involved in to implement the treatment regime were seen as senseless, primarily because the nurses defined their patients as dying. Nurses described their activities with patients in terms of "fruitless", "self-defeating", "going nowhere", "hopeless", or "nonsensical". An important feature of nurses' ethical perspectives in terms of their activities was their lack of satisfaction, and probable role conflict. Influencing nurses' ethical perspectives was their length of exposure to patients experiencing prolongation of the process of dying. Increasing exposure meant less emphasis on gaining competence in biomedical tasks, and resulted in more acute perspectives of senselessness.

Finding New Meanings

Nurses' ethical perspectives also emphasized

nurses' attempts to cope with senselessness. Coping with senselessness meant that nurses attempted to find new meanings by shifting focus, or shifting their focus of action. Shifting focus included: (a) shifting focus from the implementation of treatment regimes to patient comfort; (b) shifting focus to support of the family; and (c) shifting focus to nurses' own personal philosophy.

Shifting focus from the implementation of treatment regimes to patient comfort was described by nurses in terms of "the only thing you can do is just try and make people comfortable for whatever time they have left." Relief of suffering and promotion of patient dignity were implicit in many nurses' accounts of their focus on patient comfort. Nurses' accounts indicated that their focus on patient comfort helped them to find satisfaction in otherwise "self-defeating" activities. Influences on nurses' focus on patient comfort included nurses' use of analgesia, and their inability to communicate with most of their patients. The inability to communicate was described as making it more difficult for nurses to get to know their patients as persons.

A second, parallel, shift of focus was towards support of the family. This focus was emphasized

repeatedly through the transcripts with every participant. Most participants described a sense of purpose, or completeness when they felt they were able to focus on the family. Participants described their focus on the family unanimously in terms of support, or helping family members to know what to expect and helping them to care for themselves. Support also meant helping family members to prepare for the patient's eventual death. In particular, support meant helping family members to deal with their hope.

Influences on nurses' focus on support of the family included nurses' development of increasing competence in their nursing practice, which made them more comfortable with biomedical tasks and less reluctant to approach family members. The cultural background of the family also was an influence in that families from a different culture were often described by nurses as "more difficult" to provide support to. An excessive workload in the patient care situation meant that nurses could not always find the time to support the family. Finally, a major influence on nurses' focus on support of the family was nurses' perceptions of support from others. Positive support was experienced in terms of facilitating nurses' focus on support of the family, while the converse was also

true.

A third, concurrent focus in nurses' attempts to find new meanings was the expansion of each nurse's personal philosophy. One aspect of that expansion was experiencing and learning from people while sharing an intimate life event. Expanding their philosophy to find new meanings while caring for dying patients in a critical care setting was also intertwined with nurses' philosophies in terms of their own life. A focus on personal philosophy was a source of satisfaction for some nurses as they cared for patients who were experiencing prolongation of the process of dying in a critical care setting. Influencing nurses' focus on their personal philosophy was the amount of energy nurses felt they had for themselves. Energy for self was closely linked to perceptions of support from others. Too little energy for self was experienced by nurses in terms of needing to achieve emotional distance.

Evolving Meanings

Nurses' ethical perspectives on nursing dying patients in a critical care setting centered around a theme of senselessness and emphasized nurses' attempts to cope with senselessness by finding new meanings. New meanings were not static, but occurred over time

and were subject to a variety of influences. Energy for self appeared to have been particularly relevant in the qualitatively different kinds of meaning constructed by nurses at different points in their careers. Nurses therefore experienced meanings that continually evolved as they nursed patients undergoing prolongation of the process of dying.

CHAPTER FIVE:
CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS
FOR FURTHER STUDY

Conclusions

The conceptualization of the problem statement in Chapter One of this thesis indicated that critical care nursing has developed as a nursing specialty for patients undergoing life-threatening physiological crises, with a mandate to provide care to the whole patient, but finds itself operating within a system that has become fragmented and dehumanized. Of particular concern in the application of technology within this health-care system is the underlying assumption of patient death as failure. As a result, prolongation of the process of dying takes place for many patients in critical care settings.

Prolongation of the process of dying was seen in the literature as creating an ethical problem for nurses, with the implicit assumption that nurses will always find prolongation of the process of dying conflicting with their values of human autonomy and dignity. However, given a relative lack of ethical research and conflicting theories of moral reasoning, it was argued that we cannot assume what individual nurses' ethical perspectives will be. Therefore, the

research question for this thesis was:

"What are nurses' ethical perspectives on nursing dying patients in a critical care setting?"

Phenomenology was chosen as the methodological approach for the thesis in order to provide a full and accurate description of individual nurses' ethical perspectives. In particular, it was the investigator's intent to uncover the "concrete, idiosyncratic, and contextual" (Sullivan, 1977, p. 19).

The results of this study indicate that nurses' ethical perspectives on nursing dying patients in a critical care setting centered around a theme of senselessness. Senselessness illustrated the conflicts experienced by nurses as they cared for patients, and was associated with feelings of anger, frustration, and powerlessness. The conflicts experienced by nurses were comprised of multiple ethical dilemmas within the overall ethical problem of prolongation of the process of dying. The results of this study thus affirm other nursing studies in identifying prolongation of the process of dying a significant ethical problem (A. Davis, 1981; Fenton, 1987; Nursing '74, 1974a, 1974b).

Nurses explicated the theme of senselessness in terms of three major concerns. These concerns included: (a) a senseless decision-making process;

(b) senselessness in terms of what was being experienced by patients and family members; and (c) senselessness in terms of the activities nurses found themselves involved in to implement treatment regimes. Concurrent with nurses' ethical perspectives of senselessness were nurses' attempts to cope with their perspectives by finding new meanings. Finding new meanings was described by nurses in terms of: (a) shifting their focus to patient comfort; (b) shifting focus to support of the family; and (c) shifting focus to their own personal philosophy. This concurrent emphasis on senselessness and coping is similar to Fenton's (1987) concurrent emphasis on nurses' ethical perceptions and their attempts to cope with their perceptions. The exploration within this study of coping in terms of finding meaning is also similar to a study by Hutchinson (1984) of neonatal I.C.U. nurses. Hutchinson identified the creation of meaning as essential for professional survival. This study certainly supports that notion.

Returning to the literature reviewed on moral reasoning, it can be argued that nurses' moral choices (e.g., letting the patient die without further treatment) were unable to be translated into moral action, resulting in ethical perspectives of

senselessness. Nurses coped by making different moral choices (e.g., assisting the family in their grief process) that were more amenable to moral action. Nurses' attempts to find new meanings thus constituted the implementation of a moral reasoning process.

The contextual nature of nurses' moral reasoning is illustrated in this study through nurses' descriptions of a variety of influences on their ethical perspectives. These influences include such things as the cultural background of the patient and family, the legal climate of the patient care situation, nurses' development of increasing competence in their nursing practice, their workload in the patient care setting, and their perceptions of support from others. These influences are congruent with some of the situational constraints illustrated in moral reasoning studies such as those by R. Lamb (1985), Omery (1985), and Wilkinson (1985). Nurses' moral reasoning was thus not a matter of simply applying universal values, but was a process that changed over time and was subject to a variety of influences.

Of particular note in this study was the influence of the amount of energy nurses felt they had for themselves on their focus on their personal philosophy. Energy for self appeared to have been

related to nurses' perceptions of support from others. Too little energy was experienced by nurses in terms of needing to achieve emotional distance for themselves. Nurses' ethical perspectives as described in this study therefore support the findings from other studies (Davitz & Davitz, 1975; Fenton, 1987; Field, 1984; Lamb, R., 1985; Wilkinson, 1985) in terms of the emotional involvement of nurses with their dying patients.

Furthermore, nurses' identification of situational constraints and the multiple ethical dilemmas they experienced recall the concerns expressed by Murphy (1983), and Yarling and McElmurray (1983), that nurses are not free moral agents in our health care system. Statements from participants in this study such as "it's really bothering me" indicate that nurses' inability to function as free moral agents was a source of significant moral distress (Wilkinson, 1985).

Implications

Nursing Education

Ethical problems are receiving increasing attention in the nursing literature, and nurse educators are increasingly aware of the necessity to better prepare nurses to deal with these kinds of problems (Reilly, 1978; Reilly & Oermann, 1985). It is clear from this

study and others that ethical problems such as prolongation of the process of dying are not infrequent, and may be a source of significant moral distress to nurses. We therefore need to place more emphasis on the affective domain of nursing education as we prepare beginning practitioners in nursing.

However, within the affective domain of nursing education we need to use caution in implementing theories of moral reasoning that fail to fully explain nurses' moral behavior in the context of situational constraints. To cite Omery (1983b), "[choice] of a model of moral development should not occur until the assumptions underlying both the moral model and nursing framework have been identified and compared" (p. 14). Clearly, we need further research to select an approach to moral reasoning that provides direction to educate nurses for practice in the 'real world' of situational constraints.

Implications of this study for nursing education also address how we are currently preparing nurses for practice in clinical specialties such as critical care nursing. Descriptions from nurses in this study indicate that nurses struggled to help family members deal with an often complex grief process. Nurses made it clear that their ability to focus on supporting the

family gave them a sense of purpose as well as a sense of satisfaction. Given the current preponderance of biomedical content in nursing specialty courses, it seems evident that we need to prepare nurses with a broader base in the social sciences to help them sustain their focus on the family.

The influence of the cultural background of the patient and family on nurses' experiences as reported in this study is also relevant for nursing education. Nurses had difficulty understanding patients' and family members' decision-making or providing support in the context of different cultural variables. This investigator is in agreement with Leininger's (1984) statement that the "nurse needs a substantive knowledge base of transcultural nursing to ensure she continues to interact effectively and professionally with **all** clients" (p. 42). As educators, therefore, we need to ensure that basic and post-basic levels of nursing education help nurses acquire a transcultural knowledge base. Furthermore, we need to help nurses to implement the skills necessary for effective transcultural interaction. Anderson's (1987) Nurse-Patient Negotiation Model has been proposed as one means by which nurses could implement those skills. We need to further explore the use of models such as Anderson's to

help our future practitioners interact more effectively with their clients from different cultures.

Nursing Practice

A major emphasis within nurses' ethical perspectives on nursing dying patients in a critical care setting was their concern about a senseless decision-making process. This emphasis points out the need for a carefully planned approach to team decision-making in the clinical setting vis-a-vis treatment abatement. Such decision-making must involve the patient (if possible) as well as the family. Team decision-making needs to follow the process of rational, accountable thought called for in the literature. Mechanisms by which such decision-making can occur include ethical rounds and ethics committees (Cohen, 1982; Davis, A., 1979; 1982; Fowler, 1986 a & b; Lestz, 1977; Randal, 1983; Wlody & Smith, 1985). As we implement these kinds of mechanisms, we need to ensure full involvement of the patient, family, and staff nurse.

The influence of nurses' perceptions of support from others on their ethical perspectives calls attention to how we provide support for nurses within the hierarchy of a hospital setting. Nurses' accounts emphasized their perceptions of lack of support from

nursing administration ("no support from the upper echelons", "lone voice in the wilderness"). It would seem that we need to study perceptions of staff nurses and nurse administrators to understand how they can mutually support each other, and to develop mechanisms for this to take place.

Peer support also appears to have been an important implication of this study. Some nurses indicated that peer support was "why I can work here", while others indicated that "you just don't talk about [nursing dying patients]". We need to further study and implement mechanisms by which staff nurses can support each other in their practice.

The need to provide support to nurses may well be of some urgency. Within this study, some nurses experienced a lack of energy for self that may have been related to a lack of support from others. Expressions from nurses that they required emotional distance and felt "callous" may have involved a lessening of the quality of patient care they delivered; a consequence that was evident in R. Lamb's (1985) study. A study of the experiences of patients undergoing open heart surgery gives rise to some concern about the quality of critical care nursing practice at the bedside:

The 'busy-ness' and lack of concern on the part of nurses was cited as a common barrier to effective care. Not only did some clients perceive themselves to be misunderstood, but also poorly cared for. Contrary to professional beliefs about patient-centered care, it is evident that such care is only an ideal; it is not always realized (Yamada, 1984, pp. 195-196).

It would appear that we need to provide nurses with support in their clinical practice to help them find new meanings that are more congruent with quality patient care. Furthermore, we need to responsibly address situational constraints in the workplace such as an excessive workload ('busy-ness') and interprofessional conflicts to enable nurses to move closer to their professional ideals.

Recommendations for Further Research

Many of the implications outlined in the previous section of this Chapter imply the need for further research. However, at this point the investigator will outline some specific recommendations for future research that directly arise from this study.

The results of this study illustrated nurses' ethical perspectives as evolving over time and subject to a variety of influences. It would seem beneficial

to further study nurses' ethical perspectives on nursing dying patients in a critical care setting at different points in their careers; particularly at the commencement of their practice as critical care nurses, and at the point when they decide to leave critical care. Research to further explore nurses' perceptions of influences such as support from others and the cultural background of the patient and family would enhance our understanding of the situational context of nurses' ethical perspectives.

Two major concepts that emerge from this study include nurses' notions of support and hope. Given that these concepts were fundamental to nurses' focus on support of the family, it would seem valuable to further research how these concepts are operationalized in clinical practice.

Nurses' concerns about the suffering of patients and family members experiencing prolongation of the process of dying also points out the need for research to more fully understand what patients' and family members' experiences are. In particular, there is a need to explore the concerns of family members and their perceptions of support. Given the emphasis from nurses in this study on advocacy for family members, we need to develop a better understanding of what that

means from family members' perspectives. Nurses in this study also expressed concern about not knowing how family members coped after the death of the patient. To this investigator's knowledge, there has been no follow-up of family members of patients who have experienced prolongation of the process of dying. This would appear to be an area urgently in need of nursing research.

Looking at the literature, it would seem that we need to use caution in implementing theory from other disciplines without prior nursing research. This is fairly evident in terms of theories of moral development. It would also appear that we need to use caution in our use of concepts such as stress, burnout and attrition. This study identified that energy for self influenced nurses' focus on their personal philosophy and sometimes meant that nurses needed to achieve emotional distance for themselves. This need for emotional distance parallels descriptions of burnout in the literature (Maslach, 1982; Pines & Kanner, 1982). Burnout appears to have become recognized as a consequence of too much stress and too little coping; an end state. However, this study emphasizes nurses' ethical perspectives as evolving over time and subject to a variety of influences,

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particularly their perceptions of support from others. Notions of burnout that focus on the individual's static abilities do not give us direction to understand how individuals change over time in different contexts. In fact, it is becoming recognized in the literature that research on burnout and attrition is fragmentary and fraught with assumptions (Douglass & Bevis, 1983; Prescott & Bowen, 1987). It would appear that nurses' perceptions of and responses to stress, burnout and attrition require further study.

In closing these recommendations for future research, the investigator wishes to call attention to the need for research on the ethics of nursing practice in general. The Canadian Nurses' Association (1985) reminds us of this need in relation to our dying patients by stating that as "ways of dealing with death and the dying process change, nursing is challenged to find new ways to preserve human values, autonomy and dignity" (p. 7). The challenge must begin with nursing research.

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APPENDIX A
ADVERTISEMENT

APPENDIX B
INFORMATION AND CONSENT

1. INFORMATION: RESEARCH STUDY:

Nurses' Ethical Perspectives
on Nursing Dying Patients
in a Critical Care Setting.

I am a registered nurse working towards a master's degree at the University of British Columbia. I am conducting a study to gain a better understanding of what it is like to nurse patients in critical care when you believe they will likely die despite the application of intense medical technology. This letter is to invite you to participate in my study if you so wish. I hope that by gaining a better understanding of this situation nursing will be able to deal with it more effectively.

The procedure of the study will involve a series of approximately three, one-hour interviews scheduled at our mutual convenience. The interviews will take place at my home or yours according to your wish. I would prefer not to interview in the hospital setting because I would prefer not to be affiliated with any agency. During the interviews you will be free to comment as you wish about how you feel about nursing 'dying' patients in a critical care setting.

I will tape the interviews for convenience, but COMPLETE CONFIDENTIALITY WILL BE ENSURED THROUGHOUT THE STUDY by coding names.

I will transcribe the information I get from you and other nurses and will look for common themes frequently mentioned in the interviews.

I hope to eventually publish my results. If you choose to participate in my study I will make sure you are informed of the results. YOUR IDENTITY WILL REMAIN CONFIDENTIAL IN ANY PUBLISHED OR UNPUBLISHED MATERIAL.

YOU ARE UNDER NO OBLIGATION TO PARTICIPATE IN THIS STUDY, AND ARE FREE TO WITHDRAW AT ANY TIME. YOUR DECISION NOT TO PARTICIPATE WILL IN NO WAY AFFECT YOUR EMPLOYMENT OR MEMBERSHIP IN THE C.A.C.C.N. SHOULD YOU DECIDE TO PARTICIPATE, YOU ARE ALSO FREE TO REFUSE TO ANSWER ANY QUESTIONS.

I will telephone you next week to see if you are interested and to answer any questions. If you decide to participate in this study I will ask you to sign a form consenting to your participation, and giving me permission to audiotape our interviews.

Thank you for your interest.

Paddy Rodney, R.N., BSc.N.
U.B.C. MSN student.

2. CONSENT FORM: RESEARCH STUDY:

Nurses' Ethical Perspectives
on Nursing Dying Patients
in a Critical Care Setting.

I, _____, do agree to participate in interviews for the purpose of this research study. I agree to these interviews being audiotaped, and realize that FULL CONFIDENTIALITY WILL BE MAINTAINED. I know that I am under NO OBLIGATION TO PARTICIPATE, and I AM FREE TO WITHDRAW FROM THE STUDY AT ANY TIME. I know that my DECISION TO PARTICIPATE WILL NOT AFFECT MY EMPLOYMENT OR MEMBERSHIP IN THE C.A.C.C.N. AND THAT IF I PARTICIPATE I AM FREE TO REFUSE TO ANSWER ANY QUESTIONS. This research study has been adequately explained to me.

SIGNED _____

WITNESS _____

DATE _____

c.c. Participant

Receipt of information acknowledged _____

Receipt of consent acknowledged _____

APPENDIX C
AGENCY CONSENT FORM

AGENCY CONSENT FORM: RESEARCH STUDY:

Nurses' Ethical Perspectives
on Nursing Dying Patients
in a Critical Care Setting

The Executive of the B.C. Lower Mainland Chapter of the Canadian Association of Critical Care Nurses (C.A.C.C.N.) give their permission for the investigator to advertise for participants for the research study "Nurses' Ethical Perspectives on Nursing 'Dying' Patients in a Critical Care Setting" through their association. Advertisement will take place verbally at a chapter meeting in September 1986 and through a written advertisement in the fall newsletter.

The Executive have received an explanation of the proposed study and understand that:

- a) nurses will be under **NO OBLIGATION** to participate.
- b) participation will **NOT EFFECT NURSES' EMPLOYMENT OR MEMBERSHIP IN THE C.A.C.C.N.**
- c) nurses will be **FREE TO WITHDRAW FROM THE STUDY AT ANY TIME.**
- d) nurses will be **FREE TO REFUSE TO ANSWER ANY QUESTIONS.**
- e) **FULL CONFIDENTIALITY WILL BE MAINTAINED THROUGHOUT THE STUDY.**

Signed: _____

President

Past-President

Treasurer

Treasurer-Elect

Witness: _____

Date: _____

cc: C.A.C.C.N. Executive

Receipt of information acknowledged _____

Receipt of consent acknowledged _____

APPENDIX D
SAMPLE TRIGGER QUESTIONS

SAMPLE TRIGGER QUESTIONS: RESEARCH INTERVIEWS:

Nurses' Ethical Perspectives
on Nursing Dying Patients
in a Critical Care Setting

The following are examples of areas that may be explored in the interviews. Phrasing and terminology of questions will vary as necessary during the interviews.

1. Can you tell me about some of the values and beliefs that are most important to you in caring for dying patients in critical care?
2. Are there certain situations where your values or beliefs are changed or challenged?