Protecting Client Autonomy: A Grounded Theory of the Processes Nurses Use to Deal with Challenges to Personal Values and Beliefs

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

(Signed): ....

Acknowledgments

The journey I have taken to complete this thesis has been somewhat like a rollercoaster ride. There have been times of pure exhilaration and excitement interspersed with moments of panic and dread. But it is a journey I shall never regret for I have learned much about the topic under investigation and about myself. This would not have been possible without the support, nurture, and encouragement of many. I wish to acknowledge a few of the individuals who have played particularly important roles in helping me through this journey.

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Key to Transcript and Vignette Response Excerpts

Quoted sections from participant data (interview transcripts and vignette responses) are included in this thesis.

Please note that for ease of reading, where there is no effect on the meaning of the statement, I have excluded from the quotes:
• verbal utterances such as "umm" and "err",
• use of 'fill in' words such as "like" and "right",
• repeated words due to stuttering.

The following font and symbols have been used when including participant data in this thesis:

Italics	Used to indicate all excerpts from interview transcripts and vignette responses
…	Section of the original quote has been left out
(---)	Long pause (several seconds) by participant during interview

Abstract

Registered nurses, while carrying out their professional roles, regularly encounter situations with ethical components. While there are research findings reporting the types of ethical challenges nurses face, their level of involvement in ethical decision-making, and reasoning processes used, how nurses actually deal with situations that challenge them personally has not been specifically explored. The purpose of this study was to investigate the psychosocial processes that can explain how registered nurses reason and make decisions when faced with ethical situations that challenge their personal values and belief systems.

A grounded theory approach was used to conduct the study, allowing a substantive theory to be developed. Twenty-three nurses, currently working in metropolitan or regional areas in New South Wales, volunteered to participate in the study. Two methods of data collection were utilised, the first being semi-structured, in-depth interviews which were audio taped then transcribed. The second method used hypothetical vignettes with associated questions to which the participants were invited to anonymously return written responses. Data were managed by means of the computer program NVivo 2, while constant comparative analysis using open, axial and selective coding, as outlined by Strauss and Corbin (1998), was performed.

The substantive theory which emerged from the data explains the processes used by nurses when they have to deal with ethical challenges to their personal values and beliefs. The basic psychosocial process (core category) of *protecting client autonomy* reveals a pattern of moral reasoning that gives priority to the client's self-determined choices. This subsumes the key processes (subcategories) of: (1) *being self-aware*, (2) *determining duties to other/s versus self*, (3) *engaging self as protector*, and (4) *restoring self from tension or anguish*, which link to each other and to the core category to explain the various sub-processes used when protecting client autonomy is considered a priority. Findings in the study revealed that nurses who give primacy to client autonomy believe they should not impose their own preferred choices on to clients. Yet the emphasis on client autonomy is also paradoxical, since it may come at the cost of compromise and even denial of the nurses' own autonomy

and their deeply held values and beliefs. When they become aware that their personal values and beliefs are being challenged, they are at times prepared to compromise their own values or beliefs, yield to constraints, or put themselves at risk in order to protect the autonomy of clients. Such actions can leave nurses experiencing ethical tension or anguish for which they need to seek support. Opportunities to find appropriate support are not always available to them in the work environment.

The findings in this study have important implications for both nurses and the nursing profession. The pattern of moral reasoning shows generosity and nurses' commitment to their caring and advocacy roles. However, when nurses are regularly prepared to compromise their own values or beliefs because they give priority to protecting client autonomy, there is a risk they may be left with a sense of loss to their personal worth and in their ability to be moral agents. Further, in some situations it may occur out of complacency because they simply accept that it is the client's choice, absolving the nurse of further moral responsibility. Appropriate support systems need to be available to nurses to help them deal with the consequences which may occur as a result of giving preference to clients' choices, over their own.

Chapter 1

Introduction and Overview

Nursing is, without question, a moral undertaking. Its practice never occurs in a moral vacuum and is never free of moral risk.

(Johnstone, 2004, p. 4)

The nursing profession is fundamentally focused on promoting health, preventing illness, and caring for those who are sick and disabled (International Council of Nurses, 2002). Nurses form professional relationships with their clients[1] as they carry out nursing activities. Many of the clients nurses assist are individuals in vulnerable situations, often with acute needs. Depending on the type of care and treatment required, nurses may at times have to perform duties that in normal situations could be considered inappropriate, or an invasion of privacy. Additionally, health care delivery is continually developing new understanding and knowledge, and advancing technologically. In an environment of increasing complexity of health care provision, and greater demand for appropriate and effective therapies from health care consumers, nurses are expected to deliver professional care that is ethically justifiable.

Given what is entailed in the nurse-client relationship, and the role and goal of nursing, nurses have to regularly make decisions with ethical components to them (Chally & Loriz, 1998; Johnstone, 2004; Johnstone, Da Costa, & Turale, 2004; Raines, 2000; Spence, 1998; Thompson, Melia, Boyd, & Horsburgh, 2006). When decisions which include ethical issues are made, values and beliefs come into play (Fry & Johnstone, 2002). Such decision-making commonly requires that a choice be made between alternatives, and the values and beliefs of individuals, the community, and the profession could be involved in this process. In the complexity of clinical practice the possibility exists for tension to arise between several sets of values and opinions (Thomasma, 1994; B. J. Winslow & Winslow, 1991). My aim in this thesis

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[1] The term 'client' is used in preference to 'patient' in this thesis. The word patient is commonly used to refer to a sick individual in an acute care facility. Some of the participants in this study were involved in the care of individuals who did not fit this profile (for example, residents in an aged care facility, people with chronic illnesses living in the community) and so the more general term of client is predominantly used.

is to give some insight into what happens when competing needs and values of others challenge nurses' personal values and belief systems.

The stimulus for the study

I was a new registered nurse caring for a patient who had been admitted to an intensive care unit following an acute myocardial infarction. In our attempt to plan individualised care we, the nursing staff, noted his various requests including access by visitors. His major concern was that we ensure his wife and his girlfriend never be allowed to visit him at the same time, particularly given that his wife was unaware of the existence of his girlfriend.

I can still recall the struggle I had as I tried to decide how to respond to his request. Although my certificate level, hospital-based training had prepared me well to carry out basic nursing skills, any form of 'ethics' education extended only to learning the Nightingale pledge and the International Council of Nurses (ICN) *Code of ethics for nurses*, along with the importance of showing respect to others. The emphasis of showing respect focused particularly on being courteous to doctors and more senior nursing staff. Any likelihood of nurses encountering situations which would challenge their personal values or belief systems was not canvassed. Further, strategies to help nurses deal with such situations were neither identified nor discussed. This was not necessarily the fault of the training school I attended as it was before the era in which a focus on nursing ethics was considered essential. However, on reflection, what it does highlight to me is the difficulty individuals have when they need to make ethical decisions without appropriate decision-making tools, skills, or guidance.

For me personally, the challenge in the above scenario was that a patient had requested me, as a member of the nursing team, to carry out what I perceived to be a deceitful act by lying to another. This certainly challenged my personal values and beliefs. He had made the choice to be deceitful to his wife but was now asking me to be his accomplice in that deceit. My parents had instilled into me the importance of truth telling and now I was being asked to abandon the long-held value of veracity in this situation. Of course I still had the choice as to whether or not I would accede to

his request. However, as I thought through the possible consequences of either complying or not, I recall feeling I really had no choice, particularly if I was going to give appropriate care to my patient. After all, keeping stress levels to a minimum was seen as paramount in the care of a client who had just suffered a myocardial infarction. To expose his deceit to his wife at this time would have had the potential of greatly compromising his recovery. So it was on that basis I made the decision to comply with his request even though it caused me great personal distress to do so. I remember concluding at the time it was better I be the one who had to deal with the stress of the situation rather than he.

This is just one example of several situations I can recollect, from my nursing experience, where I felt personally challenged. Although the exact scenario may not be widespread, nurses finding themselves in situations where personal values and beliefs are challenged in the professional environment is not uncommon. Nurses often work in settings where different sets of values and beliefs prevail; therefore there are occasions when their personal values and beliefs will not be congruent with those of their colleagues, or people for whom they are caring.

It is now nearly three decades since the experience referred to above happened and there have certainly been changes in nursing during that time. One important change has been an increased recognition that nurses do encounter ethical situations as they carry out their functions and they are moral agents who have to make ethical decisions on a regular basis. To this end a focus on ethics and ethical decision-making is considered an essential component in modern nursing curricula. No longer is it accepted that nursing students are adequately prepared to deal with the ethical challenges they will encounter in their professional practice by simply teaching them a code of ethics or appropriate nursing etiquette, guised as ethics.

I am now, as a nurse academic, gratified to observe the increasing focus given to ethics education in nursing over the past several decades to the extent that in many undergraduate programs a full subject is devoted to the topic. There is also increasing acceptance nurses need to be skilled in thinking and acting ethically in all aspects of their work, rather than limiting ethics to controversial topics such as abortion and

euthanasia. The application of ethical principles, theories, and models to help guide decision-making has also assisted nurses to develop their skills in dealing with ethical challenges. However, despite the introduction of such tools, I have observed that many undergraduate students continue to be challenged by ethical situations and dilemmas, particularly when strongly held personal values are involved. Further, they identify significant emotional discomfort as they grapple to find a satisfactory solution to situations similar to the one reported earlier in this thesis.

My reflections and observations have led me to question whether nurses are eventually able to develop a satisfactory way of dealing with such challenges and discomfort, and if so, what processes are involved. When nurses find themselves in situations where their personal values and beliefs are not congruent with what is happening, how do they respond? What reasoning and decision-making processes do they use to deal with such situations? The quest for answers to these questions has been the impetus for this study.

Ethics (morals) and reasoning

Ethics is a generic term which Beauchamp and Childress (2001) state refers to "various ways of understanding and examining the moral life" (p. 1). It originates from the ancient Greek word *ethikos* which means "pertaining to custom or habit" (Johnstone, 2004, p. 10). However, ethics now more broadly refers to "a critically reflective activity that is concerned with a systematic examination of living and behaving morally" (Johnstone, 2004, p. 11). van Hooft, Gillam and Byrnes (1995) suggest "ethics is about right and wrong … it is about how people should behave, what they should do in certain circumstances and how they should treat each other" (p. 187). In short, ethics gives insight into, and justification for, what should be done in a particular situation which requires one to consider acts that might be judged right or wrong, good or bad. In the Australian Nursing and Midwifery Council (ANMC) (2002) *Code of ethics for nurses in Australia* ethics is defined as "the moral practices, beliefs, and standards of an individual/s and/ or a group" (p. 2).

Ethics is considered by society to be an important regulator of behaviour (Frankena, 1973), as is law. Nevertheless ethics and law are distinct, although both

guide action (Johnstone, 2004; Kerridge, Lowe, & McPhee, 2005). Law equates with rules with which one is obliged to adhere to avoid sanctions, whereas ethics is the application of values and principles "in order to flourish as individuals and contribute more effectively to society" (Thompson et al., 2006, p. 43). The general expectation by society is that laws apply to all individuals without variation, whereas with ethics there is recognition that individuals may have various views and opinions about an issue and one particular view is not necessarily the 'right' one.

The term morality comes from the Latin word *moralitas* and originally meant "custom or habit" (Johnstone, 2004, p. 10). It is therefore clear that ethics and morality originally had synonymous meanings, although there are some who contend the terms now differ (Jameton, 1984; Taft, 2000; Thompson et al., 2006). Where a distinction is made between the two terms, morality is accepted as referring more to "the standards of behaviour actually held or followed by individuals and groups" (Thompson et al., 2006, p. 42), whereas ethics moves beyond this to the scholarly examination of issues, values, principles, and ways of reasoning. Jameton (1984) differentiates between them by stating "ethics is the more formal and theoretical term, morals the more informal and personal term" (p. 5). However, within philosophical literature there is now some acceptance that the two terms can be used interchangeably (Johnstone, 2004; Kerridge et al., 2005; Scott, 2003; van Hooft et al., 1995). In this thesis I will use the terms interchangeably, but will use the term 'ethics' preferentially. I have chosen to do this because, although I am investigating nurses having their personal beliefs and value systems challenged, and it could therefore be argued that 'morals' might be the more appropriate term, the focus of the study in on the processes nurses use when they are personally challenged. This involves an examination of their ethical reasoning and the theoretical underpinnings used to justify their decisions. I believe the term 'morals', if accepted by some as being distinct from the term 'ethics', would be too limiting.

Theoretical approaches to ethical reasoning

Ethical theories provide "a framework within which agents can reflect on the acceptability of actions and can evaluate moral judgements and moral character" (Beauchamp & Childress, 1994, p. 44). As such, they can assist in explaining why

varied perspectives and viewpoints may exist about circumstances and problems with ethical components. The major theoretical approaches to moral reasoning which help describe Western moral philosophy have their foundations in the works of ancient Greek philosophers such as Socrates, Plato, and Aristotle, well recognised for their pursuits in understanding why individuals developed the views they had, especially in regards to what was considered right and good behaviour (Bertrand, 1979). Two major categories of ethical theories are now commonly referred to in Western ethical literature, these being deontological theories and teleological theories (Beauchamp & Childress, 2001; Frankena, 1973; Johnstone, 2004). More recently, virtue theory and principle-based guidelines have received renewed attention, particularly within health-care ethics (Beauchamp & Childress, 2001; Johnstone, 2004; Kerridge et al., 2005). A brief overview of these four approaches to ethical decision-making, selected because they are regularly referred to in current nursing literature, is provided to give a description of various approaches that may be used by nurses when ethically challenged.

Deontology

Deontological approaches to ethical decision-making focus on actions or rules when determining if something is right or wrong (Beauchamp & Childress, 2001; Berglund, 2007; Frankena, 1973). Deontology holds that certain acts are of themselves morally right or wrong irrespective of the consequences of the action (Kerridge et al., 2005). Although various philosophers have promoted a deontological approach, Immanuel Kant (1724-1804) is recognised as the philosopher who has influenced it in a major way, to the extent that it is at times referred to as the Kantian approach (Beauchamp & Childress, 2001). Various bases exist for the rules or duties held to be morally right, and thus appealed to, in order to justify moral action. These include theology (God's will), societal consensus, intuition, and rationalism (Kantian) (Kerridge et al., 2005).

Teleology

Teleological (consequentialist) approaches to ethical reasoning maintain that when deciding if actions are morally appropriate it is the outcome or consequence, rather than rules or motives, which are the determining factor. An act is right if it produces what is considered to be the best outcome (Berglund, 2007). The common

factor in teleological approaches is the pursuit of the best outcome, but there are various approaches within the category. Some of the differences are in the criteria used to assess the 'best' outcome, and who should have their interest/s considered in the evaluation of the outcome. Utilitarianism is generally accepted as the most prominent of the teleological theories and is based on the principle of utility (Beauchamp & Childress, 2001; Frankena, 1973). Even within the category of utilitarianism there are various approaches (value hedonism, act utilitarianism, rule utilitarianism) (Kerridge et al., 2005). Nevertheless, utility is the common factor so they all give focus to "always producing the maximal balance of positive over disvalue" (Beauchamp & Childress, 2001, p. 341). As such, the focus is on collective interests rather than individual rights (Johnstone, 2004).

Virtue ethics

Virtue ethics, rather than depending on particular moral rules and obligations or outcome, considers whether an action is right or wrong by examining the motive behind the action. Its origins date back to ancient philosophers, and in particular Aristotle (Kerridge et al., 2005). Virtue ethics holds that certain traits of character that are "socially valuable" (Beauchamp & Childress, 2001, p. 27), but which are not necessarily innate and can therefore be acquired through learning and practice, result in virtuous actions (Frankena, 1973). Examples of characteristics considered to be virtues include "compassion, discernment, trustworthiness, integrity, and conscientiousness" (Beauchamp & Childress, 2001, p. 32), "honesty … fortitude" (Kerridge et al., 2005, p. 16), "benevolence and justice" (Frankena, 1973, p. 65).

Virtue ethics provides a perspective beyond the possible rigidity which can result from moral rules, obligations and principles often associated with the deontological and utilitarian approaches to ethical decision-making (Kerridge et al., 2005). However, some argue it is limited in its ability "to adequately explain or justify the rightness or wrongness of actions" (Kerridge et al., 2005, p. 15). The focus virtue ethics gives to actions considered morally beneficial to the formation of therapeutic relationships should not be dismissed. Such relationships are crucial in the provision of health care so virtue theory can make a contribution to nursing even if it cannot be used exclusively.

Principle-based approaches

Ethical principles give general guidance and are not developed with the intention of providing strict prescriptive actions to be applied to particular situations. Nevertheless, a set of principles can provide a framework which assists in identifying the pertinent ethical issues requiring consideration in a given situation. This principle-based approach to ethical thinking within the broad field of health services has largely been informed by the work of Beauchamp and Childress who, in 1979, published the first edition of their book *Principles of Biomedical Ethics*. Beauchamp and Childress (2001) point out their "four clusters of principles do not constitute a general moral theory. They provide only a framework for identifying and reflecting on moral problems" (p. 15). Nevertheless, the principles, respect for autonomy, non-maleficence, beneficence, and justice have played a prominent role in biomedical ethical discussions over the past few decades.

Values, beliefs and ethics in nursing

Although the theoretical approaches outlined above are commonly referred to in the literature as approaches used when reasoning through ethically challenging situations, they do not discount the place of personal values and beliefs in the process. Johnstone (2004) points out "it would be natural for a nurse to incline toward and draw on his or her own personal values, beliefs, professional knowledge and life experience" (p. 34) when seeking solutions to ethical problems. Nurses should consider the values and beliefs pertinent to situations with ethical components that require decisions to be made. However, there is no guarantee this will always occur. There may be times when a decision is made on the basis that 'it feels right' or 'it's what we've always done'. Further, in some circumstances nurses may not even consider the ethical dimensions of a situation before they act, either because of the pressure of time, competing demands, or perhaps failure to recognise the existence of ethical issues. Nevertheless, if a nurse is going through a conscious process of ethical decision-making, his or her personal values and beliefs are very likely to come into play. Additionally, the values and beliefs of other personnel involved in the decision, along with the values of the nursing profession also require consideration (Fry & Johnstone, 2002).

The nursing profession in Australia, through the ANMC, outlines the values it considers ought to be demonstrated by nurses if they are conducting themselves in ethically appropriate ways. These value statements form a framework for the *Code of ethics for nurses in Australia*, providing a guide for how nurses meet their moral obligations as health care professionals (ANMC, 2002). The current[2] *Code of ethics for nurses in Australia* (ANMC, 2002) includes the following six broad value statements:

1. Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care…

2. Nurses accept the rights of individuals to make informed choices in relation to their care…

3. Nurses promote and uphold the provision of quality nursing care for all people…

4. Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded…

5. Nurses fulfil the accountability and responsibility inherent in their roles…

6. Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well being.

Explanatory statements are given for each of the value statements in the published document.

As is evident in these value statements, the *Code of ethics for nurses in Australia* (ANMC, 2002) acknowledges nurses as moral agents. Further, there is recognition they may face situations in their professional roles which cause conflict with their personal moral stance. In such circumstances "Nurses have a right to refuse to participate in procedures, which would violate their reasoned moral conscience (ie. conscientious objection)" (ANMC, 2002, p. 5). Where such refusal may result in risk to a client's life or welfare, nurses "must take all reasonable steps to ensure that quality of care and patient safety is not compromised" (ANMC, 2002, p. 5). Nurses

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[2] At the time this thesis was submitted a process of revision of the *Code of ethics for nurses in Australia* was underway – the revised version was still in draft form.

have a responsibility to inform employers, at the time of employment, of any foreseeable difficulties which could arise from their personal beliefs or values being at variance with their expected role. In turn, employers and colleagues should not use personal values and beliefs to discriminate against nurses in the workplace.

Further guidance as to the ethical accountability and responsibilities the nursing profession in Australia expects of registered nurses is outlined in competency standards. The *National competency standards for the Australian registered nurse* were initially developed in the early 1990s, identified as the Australian Nurse Registering Authorities Conference (ANRAC) competencies. Revised versions have subsequently been published in 1998 and 2000 by the Australian Nursing Council Incorporation[3] (ANCI), and in 2005 by the ANMC. These standards provide a benchmark for nurses, outlining the competencies expected from nurses eligible to register. Additionally they provide guidelines for the development of curricula for undergraduate nursing programs in Australia along with criteria educational institutions can use to assess undergraduate nursing students (ANMC, 2005).

The statement of national competency standards includes four domains. Competencies related to ethics are listed in the first domain of "Professional Practice" (ANMC, 2005), under the competency "Practices within a professional and ethical framework". Subcategories of competency within this area are as follows:

2.1 Practices in accordance with the nursing profession's codes of ethics and conduct …

2.2 Integrates organisational policies and guidelines with professional standards …

2.3 Practices in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups …

2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures …

2.5 Understands and practices within own scope of practice …

2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care …

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[3] This organisation changed its name in 2004 to the Australian Nursing and Midwifery Council.

2.7 Recognises the differences in accountability and responsibility between Registered Nurses, Enrolled Nurses and unlicensed care workers. (ANMC, 2005)

Behaviours, which indicate competence in each of these categories, are also listed in the published document.

Although the aforementioned code and competency standards provide nurses with general guidance as to their professional roles and responsibilities in relation to ethical issues, it must be recognised that neither document is adequate in helping nurses deal with specific situations. This is especially the case when personal values and beliefs are challenged. They do not necessarily provide a set of easy answers to ethical problems, nor is that their intention (Berglund, 2007; Johnstone, 2004). A professional code of ethics does not replace the need for an individual nurse to personally reflect on ethical situations and go through the process of seeking rational solutions to them. Australian nurses have a professional obligation to abide by the *Code of ethics for nurses in Australia* and to meet the published competency standards. However, each individual nurse comes to that obligation with a personal set of values and beliefs which can also influence thinking as he/she proceeds through the process of determining how to deal with a particular situation.

The involvement of personal values and beliefs brings one's conscience into the situation. Conscience, according to the *Macquarie dictionary* (Delbridge & Bernard, 1998), is "the internal recognition of right and wrong as regards one's actions and motives". When determining if a situation encountered is ethically challenging or not, an individual will often refer to his or her conscience. "It is generally recognised that conscience functions as a *personal* (internal) *sanction* and a *personal moral authority*" (Johnstone, 2004, p. 328 emphasis in the original). A challenge to an individual's personal values and beliefs could therefore be viewed as a challenge to his or her conscience. This requires a determination as to what is right or wrong in the situation and how to respond in a way the individual accepts is ethical and which does not compromise core values and beliefs. However, it is recognised that "Individual conscience and personal commitments sometimes confront especially

wrenching conflicts in the health care setting" (Beauchamp & Childress, 2001, p. 36), which for health care professionals, including nurses, can be stressful.

The problem

In ethically challenging situations, individuals use values and beliefs to determine their personal choices in relation to the action taken and the outcome sought. Ethical dilemmas arise when values or beliefs are in conflict and a decision has to be made as to which values/beliefs an individual is prepared to set aside and which will not be compromised. In nursing, multiple values often come into play because the values/beliefs of health care staff, clients, clients' significant others, employers and employing institutions, the profession, as well as society, may need to be considered (Berglund, 2007; Engelhardt, 1996; Gibson, 1993; Johnstone, 2004; Komesaroff, 1995; Sherman, 2006; Veatch & Fry, 1995).

If the personal values and beliefs of a nurse are congruent with those of other players involved in making ethical decisions, it is likely the process will cause little, if any, challenge. However, it is entirely possible nurses will find themselves in situations where their personal values and beliefs are at variance with those of others. When reflecting on this possibility, important questions become relevant: How do nurses respond when their values and beliefs are not congruent with those of others involved in ethical decision-making? What happens in situations where this occurs? What reasoning and decision-making processes do nurses use to deal with such situations?

The aim of this study

The major aim of this study was to examine the psychosocial processes that occur when registered nurses face ethical situations in the clinical setting that challenge their personal values and belief systems.

In the context of this study, the following definitions apply:

Ethical situations: Situations, usually involving other persons, that require an individual to make a decision; express a view or commitment; or take action based on a value, principle, or belief system, to determine between right and wrong.

Clinical setting: The environment in which a nurse carries out his or her formal, professional function. This may be in an institution such as a hospital or any other place where a person may be employed to perform the work of a registered nurse.

Value: A standard used to make comparisons or judgements against which to assess the goodness or worth of something.

Belief System: A value-based conviction or set of principles that provides a person with direction for moral reasoning or action.

Nurses working in various environments within nursing were interviewed to explore their experiences with having their personal values and belief systems challenged in the course of their work. The findings are presented as a substantive theory, developed using a grounded theory approach, which explains the reasoning and decision-making processes nurses use to deal with such experiences.

Presentation of the thesis

To identify the context for this study, outline the procedures used to conduct it, and present its findings and recommendations, this thesis is organised into ten chapters. In this first chapter I have outlined, using an example from personal experience, the impetus for conducting this study. A brief outline of the theoretical approaches to ethical decision-making commonly referred to in nursing literature has been provided as an introduction to the ethical reasoning processes nurses may use. I have acknowledged that documents such as codes and required competencies are guides only and do not provide specific answers to all ethical problems, nor are they intended to. Nurses are required to make rational, carefully considered ethical decisions. Personal values and beliefs play a role when they reason through and make decisions about ethical situations they encounter in the workplace. Inclusion of personal values and beliefs in this process brings with it the possibility of ethical

challenges and conflicts because nurses can find their own stance may not be congruent with others. Identification of this possibility has led me to identify the need to study the processes used by nurses when they encounter situations that challenge their personal values and belief systems. A brief summary of the contents of Chapters Two to Ten is now provided.

In Chapter Two I present a literature review. In line with the grounded theory approach this review does not give in-depth focus to the specific issue being researched, rather it is a review of the literature initially examined to provide rationale for conducting the current study. A more comprehensive review of the literature occurs later in the thesis and is included in the discussion sections associated with each category of the substantive theory and in the major discussion section in Chapter Nine. The literature review in Chapter Two provides a general overview of ethics in nursing, the education of nurses about ethics, the types of ethical challenges nurses currently encounter, and ethical reasoning and decision-making processes used. This review has highlighted a gap in nursing knowledge, justifying the need to conduct the current study.

In Chapter Three I provide justification for use of the grounded theory method in conducting this research study. An outline of the procedures used to conduct research by this method is given along with detailed description of how they were applied to the current study. This identifies the specific steps used to develop the substantive theory that emerged. Procedures used to indicate the study was conducted in a way which is ethically justified, and that it has scientific rigour, are also outlined.

To provide a context for the current study, in the first section of Chapter Four I give an overview of major issues occurring in nursing, and more specifically in New South Wales, at the time data for this study were being collected. Additionally, I report some of the experiences participants shared in their interviews to provide examples of situations nurses encounter that are personally challenging. This provides a background for the substantive theory which emerged from the study data, a summary of which I give in the second section of Chapter Four.

In Chapters Five to Nine I discuss, in detail, the findings of the study. There are four categories and one core category that link together to form the substantive theory which emerged from the data. The resulting theory describes the psychosocial processes that occur when nurses face situations in the clinical setting which challenge their personal values and belief systems. Description and discussion of the four categories occur in Chapters Five to Eight as follows: Chapter Five - category one 'being self aware'; Chapter Six - category two 'determining duties to other/s versus self'; Chapter Seven - category three 'engaging self as protector'; Chapter Eight - category four 'restoring self from tension or anguish'. The core category which emerged from the data was 'protecting client autonomy'. In Chapter Nine I describe it in detail and discuss its significance in the processes used by nurses to deal with ethical challenges.

In Chapter Ten I outline the strengths and limitations of the study and discuss the implications of the findings to nurses and to the nursing profession. I then make recommendations for the nursing profession to consider, particularly in relation to education and management issues. Finally, I recommend research which should be considered as a result of the findings of this study.

Chapter 2

Initial Review of the Literature

As professionals, nurses have scope to make their own decisions, and are accountable for them. They have ethical obligations to their patients, quite independent of any doctor's obligations, and must make their own decisions about what these obligations are, and how to carry them out in situations of conflicting values or competing claims.

(van Hooft et al., 1995, p. 188)

Chapter overview

In this chapter I begin by outlining the rationale of this initial literature review, the purpose of which differs from reviews undertaken for most other research approaches. The actual review commences with a general overview of the place ethics has had in organised nursing. Literature associated with the education of nurses in relation to ethics is then reviewed. A review of research studies which identify the types of issues nurses find ethically challenging then leads to a section where literature outlining the reasoning and decision-making processes of nurses is presented. Finally, literature related to the level of involvement nurses have in ethical decision-making in the workplace and the role their personal values and beliefs play in such decisions is reviewed. A gap in nursing knowledge identified from this literature review is then highlighted, providing the rationale for undertaking the current study.

Purpose of this literature review

It is commonly expected researchers will undertake extensive reviews of the literature prior to commencing their actual study. The major purposes of these reviews are to develop a strong knowledge base of the field being studied, critique previous research related to the area of interest, identify a specific area that requires further study, generate hypotheses or research questions, and determine an appropriate design and suitable methods for undertaking the new study under consideration (Schneider, Elliot, LoBiondo-Wood, & Haber, 2003).

Such thorough and in-depth understanding of existing knowledge prior to commencing their own data collection and analysis is not expected of researchers

undertaking a grounded theory study (Streubert & Carpenter, 1999). In fact, extensive reading of the literature may lead the researcher to develop preconceived ideas and notions that influence the findings, rather than the theory developing from the study data (Charmaz, 1990; Schreiber, 2001). However, it is inconceivable a researcher would have interest in studying an area unless he or she already had some previous experience in, and knowledge of, the topic. This needs to be balanced against the risk of allowing existing literature leading to "biased interpretation of the data" (Backman & Kyngas, 1999, p. 148). Dey (1993) points out "There is a difference between an open mind and an empty head … the issue is not whether to use existing knowledge, but how" (p. 63). What is crucial is that grounded theorists are clearly able to identify what they already know and believe to ensure they are true to the data and do not try to force the data to fit their own, or others', preconceptions (Schreiber, 2001).

Strauss and Corbin (1998) acknowledge that "the researcher brings to the inquiry considerable background in professional and disciplinary literature" (p. 48). This is an advantage because it helps the researcher clarify the research purpose and determine sufficient focus for the initial approach of the study to satisfy relevant academic and ethics committees if the researcher is a student. When a researcher already has keen interest in a particular area, and this is certainly a strong possibility if there is a willingness to commit the time, resources, and energy research necessitates, he/she is likely to have knowledge and preconceptions that can impact on the study procedures. The important thing is for the researcher to be clearly aware of this possibility and take measures to ensure the study findings emerge from the data, not from the researcher's own preconceptions and ideas.

Provided appropriate precautions are taken, researchers can benefit from reviewing related literature prior to commencing a grounded theory study. However, the purpose and extent of such a review needs careful consideration. Hutchinson (1993) contends that "Existing theoretical and methodological literature is used to build a case or rationale for the proposed study" (p, 205). With this in mind I undertook an initial review of literature broadly related to my area of interest as part of the process of developing my proposal for the study. The purposes of my literature review were to:

1.   Gain a broad understanding of current literature related to ethics in the nursing profession with particular focus on ethical/moral decision-making processes used by nurses and whether there is evidence that personal values and beliefs play a part.

2.   Critique existing research studies related to the topic of interest.

3.   Determine gaps in the literature in relation to my topic of interest.

4.   Justify the need for the current study.

Because the proposal for the current study was written through the year 2000, the literature included in this review was published prior to the conclusion of that year. It is acknowledged new editions/versions of some of the sources cited have been published since 2000. In such cases the pre-2001 edition/version has been maintained in this initial review because it was content in those sources which provided information that lead to the development of the research question for this thesis. Since then, as part of the ongoing process of data collection and analysis, I have continued to access and review relevant literature and this post-2000 literature is referred to in subsequent chapters of this thesis.

The literature review

The literature reviewed included the two broad categories of scholarly and research articles. Four major themes were then reviewed, these being: (1) the place ethics has had historically in nursing through to the current era, (2) the education of nurses about ethics, (3) the ethical challenges nurses encounter, and (4) the ethical reasoning nurses use and the decision-making roles they have. This has contributed to developing the research question for the current study by identifying what is already known about how much consideration the nursing profession has given to ethics and the ethical problems nurses encounter, and the measures in place to help nurses deal with them. Further, the review has identified current knowledge about ethical reasoning processes nurses use, their involvement in ethical decision-making, and whether or not nurses refer to their own values and beliefs when making decisions in their professional activities.

The place of beliefs, values and ethics in the nursing profession

From the time they were initially recognised as an organised group, nurses have contributed to the care of individuals with health care needs. The nature of ethics within the nursing profession is reviewed to develop an understanding of what has been considered to constitute 'nursing ethics'. Additionally, reference is made to the values and beliefs which contributed to nurses' involvement in nursing activities and the opportunities they may have had to voice their own considered opinions.

The Christian era

Nursing history reveals that the development of organised nursing commenced with the inception of the Christian church. Actual records of nursing are incomplete prior to this era (Donahue, 1996; Kozier, Erb, Blais, & Wilkinson, 1995). Although the sick were cared for before this time, it was usually done as part of the role of mothering, or performed by slaves. As such, it was an involuntary role. During this early Christian era the sanctity of life was strongly emphasised and human life was regarded as reverent. Performing abortions and infanticide were considered acts of murder. Because human life was so highly valued, those who devoted their lives to the care of the sick and infirm were highly respected (Bullough & Bullough, 1978).

With a motive to carry out Christian acts of caring some in the early church chose to work among the sick and were referred to as deaconesses (women) or deacons (men) (Bullough & Bullough, 1978; Calder, 1965; Mellish, 1984). Thus the first organised group of nurses was instituted. Phoebe is identified in the Bible (Romans 16:1-2) as one of these early deaconesses and is commonly recognised as the first visiting nurse (Bullough & Bullough, 1978; Calder, 1965; Donahue, 1996). Although the early deaconesses did much of their work in the homes of the sick, some actually set up hospitals in their own homes (Calder, 1965). For example, Fabiola, a widow and devoted Christian convert, is recognised as the founder of the first free hospital in Rome (Bullough & Bullough, 1978; Sabin, 1997). Established in her home in 390AD, it was a place available to the very poor who were ill. Fabiola performed many of the nursing tasks herself and is said to have "shared in the poverty of her patients" (Donahue, 1996, p. 87). Similarly, Paula, considered a very learned woman, converted to Christianity following the death of her husband and established

hospitals in Rome and Palestine. She was recognised for her compassion and devoted about 20 years of her life to the care of the sick and needy (Donahue, 1996). Fabiola and Paula, and others like them such as Marcella, were women highly regarded for their intelligence and leadership abilities and the practical ways in which they displayed their values and beliefs.

These early nurses were respected, often came from well to do families with power, and were "ranked with the clergy" (Calder, 1965, p. 23). Such commitment stemmed from their belief in, and love for, Christ and His teachings and the desire to do altruistic acts of charity. As a result the care of those who were infirm became an activity which was considered a valued sacred duty rather than a necessary obligation performed simply because of status (Calder, 1965; Donahue, 1996). These early Christian nurses gave unselfish focus to the poor, needy, and sick, their values and beliefs providing motivation for such activity rather than causing them moral challenge.

However, it needs to also be acknowledged that religious influences on nursing also led to restrictions on personal expression and opinion. With the rise of religious orders, strict discipline was introduced. Nurses were expected to be unquestioningly obedient, especially to those who were the decision-makers in more powerful positions such as the clergy and doctors. As a result, "an individual nurse's accountability, the personal responsibility for decision making in regard to patient care, was thus bypassed and totally alien in nursing for many years to come" (Donahue, 1996, p. 80).

The dark period of nursing

History records the worst period in nursing to be from 1500 through to 1860. Commonly referred to as the 'dark period of nursing', nurses were generally women who were ex-patients or prisoners, and who were "illiterate, rough, and inconsiderate, oftentimes immoral or alcoholic" (Donahue, 1996, p. 191). Rather than a career option for those who wished to make a socially acceptable contribution to the community, nursing was often a last resort for low status women who could no longer earn a living by gambling or living immorally (Calder, 1965).

This marked change occurred mainly as a result of societal changes brought about by the Reformation when, with closure of many hospitals, religious orders were restricted in their contribution to care for the sick (Chitty, 1997; Donahue, 1996). When the need for re-opening some of the hospitals became apparent it was done out of necessity rather than charity, and the hospitals were staffed by lay people (Deloughery, 1977). The values held by secular nurses during this era were in sharp contrast to those held in the early Christian era (Bullough & Bullough, 1978). Those who carried out nursing duties did so because, as a result of poverty or crime, they had no other option. Given they were forced into such a work environment any opportunity to voice their own opinion, if indeed they even felt ethically challenged, was not made available.

In countries outside of England and Europe where there was institutionalised care of the sick and infirm, such as the United States of America and Australia for example, the situation was unfortunately similar. Nursing care was at a poor level and often provided by prisoners or those with low social status unable to carry out other work (Bowe, 1960; Bullough & Bullough, 1978; Chitty, 1997; Donahue, 1996). Although there were attempts in some institutions to make reforms they were either short-lived or ineffective.

It is acknowledged that the descriptor 'dark period of nursing' is usually used in reference to nursing conditions in Europe and England during that era. However, there are rare examples of exceptions to this description, as illustrated by the work of St. Vincent de Paul (1576-1660) (Bullough & Bullough, 1978). He organised a society of women to carry out charitable acts for the poor and needy, including care of the sick in their homes. The women were often from the upper-class, although at times it was their servants who did the actual work. Those involved in the care of patients were expected "to obey the physicians and to treat them with respect" (Bullough & Bullough, 1978, p. 62). His work spread throughout France and Poland and eventually led to the establishment of hospitals.

Change for the better in nursing was also occurring in a small but significant way in Germany towards the end of this era. Pastor Theodore Fleidner established the Deaconess Institute at Kaiserswerth in 1836. By 1842 it had developed into a major hospital with a program that trained women who believed they had a calling to care for the sick (Chitty, 1997). The three year program included clinical experience, and instruction in nursing theory, pharmacology, religious doctrines and ethics. However, the nurses were taught that obedience to the physicians' orders was paramount because responsibility for patient outcomes rested with the physician alone.

The Nightingale era

Nightingale is recognised as "the pioneer and founder of modern nursing as well as a reformer of hospitals" (Donahue, 1996, p. 197). Such recognition exists because of the revolutionary changes she made to nursing, pulling it out of the misery of the dark period. In part, the changes happened because she encouraged women of good character to choose nursing as a career. This occurred despite the fact she came from an upper-class family with wealth and she could easily have chosen to live a life of luxury and ease (DeLaune & Ladner, 1998).

Nightingale emphasised the importance of moral character in nurses. Baly (1969) states that:

> Miss Nightingale saw the main object of nurse training as being the development of character and of self-discipline with moral training being more important than mere academic education – 'you cannot be a good nurse without being a good woman' she was fond of saying. (p. 25)

The importance Nightingale (1969) placed on good character and conduct is evident in the following section of her famous book *Notes on nursing*, first published in 1860:

> And remember every nurse should be one who is to be depended upon, in other words, capable of being a 'confidential' nurse … she must be no gossip, no vain talker; she should never answer questions about her sick except to those who have a right to ask them; she must, I need not say, be strictly sober and honest; but more than this, she must be a religious and devoted woman; she must have a respect for her own calling, because God's precious gift of life is often literally placed in her hands; she must be a sound, and close, and

quick observer; and she must be a woman of delicate and decent feeling. (pp. 125-126)

It is acknowledged this publication by Nightingale was not written with the intention of it being a text on nursing ethics. In fact, Nightingale maintained it was not even to be considered as a manual to be used when educating nurses. Rather it was a guide for all women who found themselves in situations of having to care for others, in particular their own families (Dolan, 1969). The mention of the importance of nurses maintaining confidentiality, having integrity, being religious, and not being consumers of alcohol is only a short component of the book. However, it provides an example of the focus given to behaviour or conduct by nurses during that era.

There is evidence Nightingale's own beliefs and values were a major influence on her chosen work. When aged 16 years, she had what "she referred to as her 'Call from God'" (Dossey, 2000, p. 33) and it was this that motivated her to work for the poor and sick. When 32 years old, she spent three months at the Deaconess Institute at Kaiserswerth in Germany where a program, advanced for that era, taught ladies the skills required to be nurses. This was the impetus to a career that saw reformation in nursing and healthcare. Such change did not occur from a woman who was simply docile and obedient. Nightingale was prepared to question authority and hold forcefully to her opinions in order to bring about changes she believed were required. This took moral courage, strength of character, and a clear sense of personal and professional values.

The ideas developed by Nightingale spread throughout England, and subsequently abroad, as a result of Nightingale trained nurses taking her methods and ideas to countries such as the United States of America, Australia, and Canada. Additionally, nurses whom she had trained provided care to British troops in various conflicts including those in South Africa and Egypt (Bullough & Bullough, 1978; Dossey, 2000). Many of these women similarly needed to have a strong sense of personal and professional values to sustain them. Several of them encountered challenges, particularly from the medical profession and hospital administrators, as they attempted to establish hospitals and nursing schools that required the establishment of new structures or models (Dossey, 2000; Schultz, 1991). Lucy

Osburn, who arrived in Australia in 1866 with a team of five Nightingale nurses, is such an example (Burchill, 1992). The ability to pursue goals for the betterment of healthcare and nursing is indicative of the values, commitment, and strength of character possessed by these women.

The post-Nightingale era

A focus on the behaviour and etiquette of nurses continued for several decades during the post-Nightingale era. Nurses were taught that loyalty to doctors and "the virtues of truthfulness, honesty, and integrity" (Fry, 1989, pp. 487-488) were required. An emphasis on obedience, cheerfulness, kindness, trustworthiness and reliability is apparent in a nursing text, published in 1948, which devoted just one page that was titled 'nursing ethics'. The text defined ethics as "a code of moral behaviour … [which] included the moral qualities and rules of conduct relating especially to nursing" (Houghton, 1948).

However, it would be inappropriate to believe that expectations of obedience, respectfulness, or subservience always resulted in nurses who were down-trodden, voiceless and dependent. There are many examples of nurses in the post-Nightingale era who, like Nightingale, displayed moral courage and had to make difficult ethical decisions. English nurse Edith Cavell illustrates this. Having founded a nurse training school in Belgium, she remained there when World War I commenced. She continued to care for sick Germans while assisting British and French soldiers to escape Belgium. Selflessly refusing to escape herself when opportunity presented, the ultimate price was paid for the decisions she made when eventually she was captured and executed by a German firing squad (Donahue, 1996).

There are also examples of World War II nurses who were prepared to work in situations of great hardship, risking disease, capture, or death (Chitty, 1997; Donahue, 1996). The story of Australian nurse Vivian Statham (nee Bullwinkle) who served as an army nurse in World War II is indicative of the heroism shown. Off the coast of Sumatra she survived the sinking of the ship on which she was being evacuated, an attempted execution by enemy soldiers, and nearly four years in war camps. Yet she never lost sight of her calling as a nurse and remained working in the

profession until her retirement in 1977 (Best, 1988). Despite the harrowing experiences she endured when a prisoner of war, she was still prepared to help others as much as she could, commenting "there was damn little to give, only their sheer nursing ability" (Best, 1988, p. 58).

Nurses who have shown such great moral courage and high principles often do so because their personal values and beliefs motivate them. This includes those who have allowed themselves to be placed at risk of contagious diseases, some at times succumbing to the infections suffered by the patients for whom they cared, and dying. Others have chosen to work in isolated environments to ensure those who settled in rural, remote and frontier settings would still have access to healthcare services (Burchill, 1960, 1992; Donahue, 1996). Still others, motivated to use their nursing skills in mission endeavours, served as nurses in foreign countries, at great personal sacrifice at times (Langmore, 1989). Although the examples given are by no means exhaustive they serve to illustrate that countless nurses in the post-Nightingale era moved beyond the commonly accepted perception that nurses were obedient servants. Many of these nurses confronted circumstances that required them to reason through and act on complex ethical issues.

Fry (1995) asserts that as the nurse's role changed from that of an obedient physician's helper to a more independent practitioner, following World War II, it was accompanied by "a shift in the understanding of nursing ethics" (p. 1823). By the late 1980s there was increasing acceptance within the profession that nurses are moral agents and therefore ethics needed to be included in their education (Davis & Slater, 1988). However, while nurses were increasingly giving focus to their ethical responsibilities, they often faced challenges from those outside of the profession. Such attitudes meant nurses were still given very limited opportunities to be involved in ethical decision-making and to voice their own reasoned opinions. The image of the nurse as an obedient servant to the doctor had changed. But the notion of obedience was still in existence to some extent, although its construction had changed to nurses being the ones to carry out care delegated by doctors.

Historically, the dismissing of ethics as a component of nursing practice has been particularly evident by some members of the medical profession. The opinion that only doctors have the ability to make ethical decisions in relation to patients still exists in the minds of some (Johnstone, 1999), although recent evidence suggest some within the medical profession acknowledge a place for nursing ethics per se (Thomasma, 1994). Additionally, "the media, interdisciplinary bioethics forums, the legal system … and the internationally reputed *Encyclopedia of bioethics* … have contributed to the marginalisation of a nursing perspective on ethical issues in health care" (Johnstone, 1999, p. 10). The failure, by various groups, to give credence to the role of nurses in moral decision-making is well summed up by Clay (1987), who wrote:

> Many assume that because it is doctors who decide when to turn off the ventilator, the lawyers who pronounce on issues such as surrogacy, the scientists who play around with *in vitro* fertilisation, and the managers and politicians who decide where limited health resources are put, then the nurses have no separate responsibilities. And there is a supposedly sympathetic way of thinking that wants to keep nurses out of all this intellectual and moral agonising. (pp. 39-40)

Even within the nursing profession, there has been some debate as to whether nursing ethics should be categorised under medical bioethics (Veatch & Fry, 1987), not made distinct from medical ethics (Melia, 1994a), or be granted an independent place (Johnstone, 1999). Johnstone (1999) strongly argues for the latter, pointing out that "Nursing ethics already exists in its own right, and this existence is no less warranted than any other ethical perspective" (p. 48).

I would argue that denying nurses the status of moral agent is not defensible because there is now strong evidence that nurses regularly engage in situations that have an ethical component, requiring them to make moral decisions. Given the moral responsibilities nurses independently have to clients, they "must make their own decisions about what these obligations are, and how to carry them out in situations of conflicting values or competing claims" (van Hooft et al., 1995, p. 188). Further, they cannot be isolated from the moral dimensions of clinical practice. Even in situations

where they do not make decisions themselves, they usually have to act out the repercussions, and carry the moral burden, of others' decisions.

The current era

Research evidence clearly indicates that, currently, nurses in various clinical environments regularly encounter situations that have ethical components to them (Chally & Loriz, 1998; Gold, Chambers, & Dvorak, 1995; McNeill, Walters, & Webster, 1994; Omery, 1995; Raines, 2000; Redman & Fry, 2000; Wilkinson, 1987). It is all too easy to reserve contemporary ethical accountability and decision-making to those complex ethical issues often identified in bioethical discourse such as the use of reproductive technologies, abortion and euthanasia. However, much of the activity in current nursing roles, particularly in relation to interactions with clients, requires nurses to consider the ethical implications of their everyday actions.

Bishop and Scudder (1990) assert that nursing can be defined as a "moral practice based on the moral requirement to promote well-being of the patient by caring for him or her by a personal relationship" (p. 104). Given the importance of the client-nurse relationship to the fundamental role of nurses, they cannot escape their ethical responsibilities in everyday tasks. Giving focus to the doctor-patient relationship, Komesaroff (1995) acknowledges that clinical decisions with an ethical component occur in situations that can initially be considered simple and straightforward. They are not confined just to the big questions linked to life and death. He contends "Every aspect of the relationship between doctor and patient is suffused with ethical consideration" (Komesaroff, 1995, p. 69). Decisions made in regard to these everyday interactions are, he suggests, at the microethics level. The same, I would argue, applies to interactions between nurses and patients.

For example, although the task of determining which of two patients will be given care first should, for the most part, be a clinical decision, one cannot escape the fact that there are also moral dimensions involved. Ideally health care need should be the factor that is used to decide. But it is also possible the nurse may consider his or her own personal preferences in the situation and that could introduce issues of justice and integrity. Even the way in which a nurse approaches a patient brings with it the

possibility of moral risk. A nurse could choose to approach a patient in a way that is dismissive of the individual and such an encounter would very likely be judged as morally inept. However, if a nurse decides to ensure the approach is made in a way that enhances trust in the nurse-patient relationship, it is viewed as being morally responsible. In such situations it is conceivable a nurse's personal values and beliefs could influence the way he or she decides to carry out nursing activities. This would, in part, depend on how much the nurse allows personal views to influence professional decisions.

Nurses have to at times care for clients who are not easy to work with. Some clients may be demanding, rude, abusive, inconsiderate of others, or non-compliant, to list just a few possibilities. The way in which a nurse treats and communicates with such individuals has as much to do with personal beliefs and values as is it does with professional training. A situation where a nurse is required to look after a patient who has just killed an innocent bystander while driving under the influence of alcohol, does not easily evoke sympathy. In order to show respect and kindness towards such a patient, or to even accept that such consideration is merited, requires the nurse to draw on personal values that will support such action.

Thomasma (1994) points out that the complexity of nursing ethics means application of traditional rationalistic approaches to ethical problems is not appropriate. In part, this is because "nursing ethics is not what patients do or what nurses do but the way the dynamic of the healing relationship unfolds … A relationship is the most elusive of all realities, yet the most important to human beings" (Thomasma, 1994, p. 94). The importance of this relationship is also emphasised by Gastmans, Dierckx de Casterle and Schotsmans (1998) who suggest that "the quality of nursing care must always be seen in light of the relationship between a unique nurse and a unique patient" (p. 47). However, this at times can be challenging. Health care clients are not always attractive or endearing human beings, appreciative of the care they are given. Nor are nurses always pleasant providers of care with unlimited patience, tolerance, and time at their disposal.

The nursing profession acknowledges that nurses currently work in environments where ethical standards apply and where nurses encounter situations that have moral components and, at times, ethical challenges. This is indicated, in part, by the publication of various nursing codes of ethics and related documents to provide nurses with general guidelines. Such codes identify to members of the profession the principles or values commonly shared by those within the profession and to which it is expected individual members would wish to subscribe (Bergland, 1998).

In Australia, the nursing profession provides nurses with guidelines to assist them in understanding what is ethically acceptable practice and their responsibilities in regard to this. It also identifies the competencies registered nurses need to achieve in order to be considered ethical professionals. The competencies are in a section of the ANCI *National competency standards for the registered nurse (ANCI, 2000)*[4]. An ethical decision-making role for nurses is clearly identified in the competency that a registered nurse "engages effectively in ethical decision making". In addition, a nurse considered competent will abide by the profession's ethical codes, and demonstrate cognisance of current ethical issues impacting the profession. The codes being referred to are the *Code of ethics for nurses in Australia* (ANCI, 1993) and the *Code of professional conduct for nurses in Australia* (ANCI, 1990). The two codes are considered complementary to each other with the *Code of ethics for nurses in Australia* focusing on "the morals and ideals of the profession" (ANCI, 1993), and the *Code of professional conduct for nurses in Australia* focusing on "the clarification of professional misconduct and unprofessional conduct" (ANCI, 1990).

The *Code of ethics for nurses in Australia* (ANCI, 1993) acknowledges that while involved in professional activities, a nurse may find his or her personal values or beliefs being violated. In such circumstances, the nurse has a right to conscientiously object to being involved in such activities unless the life or welfare of a client would be endangered as a result. By identifying this right, the possibility that personal values and beliefs do at times come into play in the professional arena is

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[4] It is acknowledged that new editions of each of these three ANCI documents have been published since the dates identified, however the publication dates shown indicate editions current at the time of the initial literature review when the research problem was being determined.

acknowledged. However, the code does not clearly acknowledge the ambiguity and the complexity of the moral dimensions of nursing. One could conclude that anything short of a violation, or a situation requiring recourse to conscientious objection, is not considered an issue. Its ability to provide nurses with appropriate guidance at a microethics level, in everyday practice, is therefore limited.

The unique therapeutic relationship that exists between nurses and their clients now requires nurses to have appropriate knowledge and understanding of ethics as it applies to all dimensions of their role. If nurses fail to give careful consideration to the ethical issues in their everyday practice and interactions, their ability to provide professional care to their clients in a way which takes into account the needs of each individual client is jeopardised.

The education of nurses about ethics and moral reasoning

Recognition of the need to give serious focus to educating nurses about ethics, and the moral reasoning and decision-making processes used, has been evident only in the past few decades. To illustrate the limited place ethics has had historically in nurse education and nursing textbooks Killeen (1986) reported that a survey of 42 textbooks on the fundamentals of nursing, published from 1965 to 1985, revealed that only 55 per cent of the texts contained some ethics content, mainly giving focus to codes for nurses. Two of the texts had a full chapter devoted to ethics while just one had two chapters. Gaul (1989) comments that the lack of ethics content in nursing texts at this time disadvantaged neophyte nurses when they entered the clinical areas and were exposed to actual dilemmas. However, while there was limited content on nursing ethics as reported above, there were books being published that did give some focus to nursing ethics. In fact, Jameton (1984) points out that "no decade has passed since 1900 without publication of at least one basic text in nursing ethics" (p. 36)[5]. Nevertheless, it appears nursing ethics was treated, not as an integral part of the preparation to be a nurse, but as a specialised domain of knowledge for those interested to read about it in separate texts.

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[5] Some of Jameton's examples include: Lükes (1888); Robb (1900); Lounsberry (1912); Aikens (1916); Gladwin (1937); Moore (1943); McAllister (1955); Storlie (1970)

In Australia, early references in nursing journals to the teaching of nursing ethics occurred but the focus, as was common in the early to mid-1900s, was on conduct and etiquette rather than moral reasoning (Elkan, 1935; Lockwood, 1910; The Trained Nurse, 1917). The priority given to nurses showing loyalty to doctors was emphasised. For example, Bell (1937) wrote "As loyalty to the medical profession is the first article in the instruction of nurses in ethics …" (p. 160), identifying the precedence given to conduct, particularly in how nurses related to doctors. However, the precedence given to loyalty changed over time. More recently there have been developments in several areas in relation to nursing ethics. Fry (1995) identifies these as the development or revision of codes of ethics, changes in the way nursing ethics is taught, empirical studies of moral development and practice in nursing, the philosophical analysis of the moral concepts in nursing, and nursing ethics theory development.

Describing the teaching of ethics to nurses in the USA, Fry (1989) identifies that when ethics was initially introduced into nursing programs, because it was viewed as a science, the scientific model was the method used. Ethics was considered a science because of its focus on the right and wrong of human actions as a universal concept for all humankind. As such, it was viewed as having equal importance to the other sciences nurses needed to learn during their training. The major content included in this model focused on students gaining understanding of themselves and their community, and learning what their duties and obligations were in line with accepted ideals and customs of the time. The approach did provide nurses with the opportunity to consider their own personal characteristics and duties to themselves. However, there was also emphasis on what was appropriate moral conduct based on community expectations. Fry (1989) points out this model "was apparently a component of every curriculum in nursing [in the USA] prior to the 1950s. Ethical excellence on the part of the nurse was taught, expected, and required" (p. 488). In fact, in the 1930s and 1940s, the National League for Nursing required ethics to be included in all nursing programs, and further, it needed to be in the early part of the course. It is, however, important to note that the content of such teaching focused on conduct and behaviour, so tended to be etiquette rather than ethics. It did not give

regard to the reasoning and decision-making processes nurses could use when facing moral conflicts.

It appears that, in the USA at least, the application of the scientific method to the teaching of ethics disappeared by the 1950s. Except in nursing programs that had religious influences, ethics was not part of nurse training programs again until the 1970s (Fry, 1989). Even in the 1970s it was included in only a limited number of courses. In a survey of 86 nursing programs conducted in 1977 by the Hastings Center, only six were found to require ethics content in their courses (Andrews & Hutchinson 1981).

Due to influences such as the American Nurses Association *Code for Nurses* and results from Aroskar's (1977) study focusing on the teaching of ethics in nursing programs, many nursing faculties began to introduce ethics into their curricula in the 1980s. These influences also led to the development of the Moral Concepts Model as a framework for teaching ethics, with a focus on the major areas of historical foundations, value dimensions in nursing, and ethical decision-making (Fry, 1989). Other approaches have been developed subsequently, including the Moral Issues Model, The Clinical Practice Model, and the Ethics Inquiry Model (Fry, 1989). The latter model tends to be used in postgraduate academia, while the Clinical Practice Model lends itself to discussions within multidisciplinary situations. The Moral Issues Model includes the foundations of ethics (including theories), ethical issues in relationships, and issues causing dilemmas, and this model is often used as a framework for texts on ethics and for teaching undergraduate nurses, even in the current era.

The inclusion of ethics in Australian nurse training in the 1960s, albeit at a limited level, is evident in a statement by Shield (1966) who commented:

> To the present time, I believe it is fair to say, the teaching of ethics as such has received, of necessity as a result of pressure of time, minor consideration in the classroom, though, without doubt, ethics has, to some extent, entered into the teaching of almost every subject in both classroom and clinical area. (p. 325)

It is apparent from this account that the inclusion of ethics in the training program was not mandatory or carefully planned. She then went on to propose that a subject titled 'Ethics Applied to Nursing' be included in a new curriculum being developed. Topics she believed ought to be covered included: moral values; development of personal moral theories; rights and duties; free will; issues related to "punishment, retribution, correction, and deterrence" (p. 326); and professional ethics. She further stressed the need to have the subject taught by nurses, although others, such as religious ministers and doctors could have some input. Although a limited number of formal lectures was relevant she emphasised the use of open discussion, both in the classroom and clinical environment, as a preferred method of teaching. Her proposal appears quite revolutionary and would, I believe, continue to be considered as having merit in the current era. Given that the term 'bioethics' did not emerge into the public arena until 1970-1971 (Reich, 1994), to suggest that ethics be included in nurse training to the extent recommended was certainly ground-breaking. Shield's proposal is indication that at least some within the nursing profession were already recognising the essential place of ethics in nursing, and the need for its inclusion in the education programs with consideration given to moral decision-making by nurses.

It was another two decades before empirical evidence was published supporting the need for Australian nursing programs to include education in ethics. Davis and Slater (1988) briefly reported findings of a cross-cultural descriptive study of nurses in Australia and the USA, investigating the participants' attitudes and beliefs about passive euthanasia. Nurses from both countries indicated they had "experienced difficulty in these and other types of ethical dilemmas" (Davis & Slater, 1988, p. 18). Additionally, there were discrepancies between what some of the nurses believed was the ethical thing to do and what was actually done. The results, the authors asserted, indicated bioethics should be included in nursing programs and that there was a need for nursing services to provide arenas for ethical issues to be discussed. The content of such courses, they suggested, "should assist nurses to identify the elements of an ethical dilemma, to reason through it and to articulate an ethical stance" (Davis & Slater, 1988, p. 19). Further, they contended ethics should be taught to both nursing students and qualified nurses through formal programs as well

as in in-service and continuing education activities. They claimed this was necessary because nurses work in bureaucracies where very complex ethical issues arise. There was therefore a need to provide nurses with appropriate knowledge to deal with such issues as well as opportunity to have more informal discussions about dilemmas occurring in their particular work environment.

It is perhaps no coincidence that through the 1980s increasing focus was given to including ethics in nursing curricula in Australia, either as a discrete subject, or integrated through the program. This development coincided with the transfer of nurse education from the hospital-based apprenticeship method to the education of nurses at tertiary institutions. Initially commencing in NSW in 1985 the transfer was completed Australia-wide by 1993 (Russell, 2000). With recognition of the changing role of the nurse, and the need for nurses to be aware of their moral responsibilities, the inclusion of ethics as a component of the curriculum was taken on board by nurse academics (McMillan, 1989; Russell, 2000). The development of a *Code of ethics for nurses in Australia*, in the early 1990s, culminating in its publication in 1993, also further enhanced the focus given to nursing ethics and the moral responsibilities of nurses in Australia in that era (ANCI, 1993).

Also in the 1980s growing numbers of textbooks specifically devoted to nursing ethics were published, particularly in the USA and the United Kingdom. This was an important development as it helped to emphasise the uniqueness of ethical issues with which nurses had to contend, as opposed to members of the medical profession. Moreover, it gave nurses the encouragement they needed to speak out on moral issues in the multidisciplinary context. Major examples of authors of acclaimed texts at this time were Bandman and Bandman (1985), Davis and Aroskar (1978; 1983), Jameton (1984), Johnstone (1989), Murphy and Hunter (1983), Rumbold (1986), Thompson, Melia and Boyd (1983), Thompson and Thompson (1985), Shelly (1980), Tschudin (1986), and Veatch and Fry (1987). The text by Johnstone was the first of its type published specifically for the Australian context. Several of these authors have continued to publish updated editions of their books and have made a valuable contribution to the literature in nursing ethics.

Discussion and research about the need to include ethics as a formal part of nurse education programs, along with the topics that should be included, was not confined to Australia. In the 1980s a large national study conducted in the USA found that approximately two thirds of nursing students reported ethics had been included as coursework in their programs (Cassells & Redman, 1989). This was a significant increase since a study by Aroskar (1977) who reported that only seven per cent of nursing baccalaureate programs required ethics to be included. Cassells and Redman (1989) also identified eight key ethical issues nurses were likely to encounter in practice: informed consent; resuscitation/ discontinuation of life-saving treatment; poor prognosis/terminal illness; level of competency; refusal of treatment; withholding information; allocation of scarce resources; confidentiality. They recommended that course work relating to these areas be included in undergraduate nursing programs. The list gives a useful overview of issues considered important in nursing ethics during the 1980s in the USA. It is also noted that the topics listed continue to be important issues at the current time.

There is evidence from studies conducted with nurses in the USA that the inclusion of education specifically in ethics contributes to the development of skills in using formal ethical decision-making models (Hughes & Dvorak, 1997) and in knowing if particular actions should be taken (Gaul, 1989). Higher educational experiences generally, not just in the area of ethics, also appear to contribute to the ethical development and competency of nursing students (Dierckx de Casterle, Janssen, & Grypdonck, 1996). However, in the early 1980s, Clay, Povey and Clift (1983), all nursing lecturers in England, pointed out nurses were not being well prepared to deal with the moral dilemmas they confronted. In presenting an example of an issue which nursing students ought to consider (such as instructions from a Paediatrician to not feed an infant with congenital abnormalities without first consulting with the parents) Clay et al. (1983) asked a pertinent question: "How does the nurse resolve the moral dilemma presented by such a situation in which personal beliefs and concern for the parent's views and feelings are set against obligations to carry out medical instructions?" (p. 300). Such a question illustrates the need to make ethics, including content that gives focus to challenges to personal values and beliefs, a mandatory part of nursing education.

All nurses undertaking undergraduate programs in Australia are now required to study ethics as a component of their course. This became a mandatory part of pre-registration nurse education following the inclusion of the domain "Professional and Ethical Practice" in the second edition of the *National competency standards for the registered nurses* (ANCI, 1998). The first edition of the competency standards were initially adopted in 1990 by the various nurse regulatory authorities in Australia. However, a study subsequently found a focus on ethical behaviour by nurses was lacking (ANCI, 1993), and this failure was in fact a major impetus for the development of the *Code of ethics for nurses in Australia*. The limitation was addressed in the second edition of the national competency standards which stipulated that the registered nurse "Conducts nursing practice in a way that can be ethically justified" (ANCI, 1998).

The inclusion of ethics in undergraduate nursing programs is also deemed essential because of its epistemological value. In her seminal work, Carper (1978b) identified four patterns of knowing considered fundamental in nursing: empirical, ethical, aesthetic and personal. Ethical knowing mainly involves how one manages conflicts between values and determining what is right and appropriate in the professional environment (Johns, 1995). Each of these patterns of knowing is considered an important part of nursing knowledge overall, each contributing in its own right, but also interdependently. Carper (1978b) asserted that "each pattern may be conceived as necessary for achieving mastery in the discipline but none of them could be considered sufficient" (pp. 21-22). Ensuring undergraduate nurses are exposed to learning experiences that will facilitate the gaining of knowledge in each of these four areas is now commonly acknowledged by the nursing profession as necessary. This necessity arises because nursing, rather than being a routine application of protocols, is contextual, individualised, responsive to clients' needs and backgrounds, and requires discretionary judgement.

It is now expected nurses will study ethics as a part of the undergraduate program. This occurs, in part, to assist them in the development of skills to reason through and deal with ethical challenges they may encounter in their work. However,

it is apparent that investigating whether these skills prepare them to deal with situations that challenge their personal values and belief systems has not been adequately studied.

The ethical challenges nurses encounter

Nurses face situations and moral dilemmas which frequently require them to make decisions about their actions or involvement in a given situation. Wilkinson (1987) contends that the frequency with which nurses encounter ethical challenges is not simply dependent on the types of clients nurses care for. Rather, ethical challenges are dependent on the type of setting, what the individual nurse determines is an ethical issue, and the nurse's belief system. As an example, Wilkinson (1987) suggests that:

> in instances of performing a Code Blue some nurses would suffer moral distress if resuscitation *was* done, while others would suffer moral distress if resuscitation was *not* done, depending on their beliefs about quality of life, killing, and letting die". (p. 21 emphasis in the original)

Participants in Wilkinson's (1987) study reported they experienced ethically challenging situations frequently, with only three out of 24 indicating the frequency as less than once per week.

Ethical problems require an individual to consider a value, principle, or belief system, to determine between right and wrong. It is therefore quite conceivable that when nurses encounter situations which challenge them ethically, their personal values and beliefs systems are involved. A review of studies identifying the types of situations that cause nurses to feel ethically challenged will identify circumstances in which these values and beliefs may come into play in the professional setting.

The Australian context

A descriptive survey of public and private hospital administrators in Australia (McNeill et al., 1994) illustrates the various types of ethical concerns nurses encounter. The study was conducted "to identify the most common ethical issues of concern in Australian hospitals" (p. 63). Findings reported these related to 'end of life' decisions, patient autonomy, questions of resource distribution, and communication difficulties. Some of the respondents in the survey were from

disciplines other than nursing, however, 34 per cent were nursing administrators. Clinical staff from various disciplines were also included but comprised only seven per cent of the sample. The listing indicates the diversity of issues likely to be faced by health-care professionals. Given the issues are commonly faced in health care settings, there is a high chance that nurses will confront them in the course of clinical practice. However, it is acknowledged the small representation by practicing clinical nurses limits the findings of the study.

Other studies conducted in Australia over the past two decades have focused on Australian nurses' attitudes to specific issues or experiences in particular clinical environments, rather than identifying the actual types of ethical issues encountered. These have included euthanasia (Davis & Slater, 1989; Kuhse & Singer, 1992; McInerney & Seibold, 1995), end-of-life issues (Cartwright, Steinberg, Williams, Najman, & Williams, 1997), HIV/AIDS health care provision (Bennett & Duke, 1995), do not resuscitate decisions (Manias, 1998), ethical issues faced by neonatal nurses (Spence, 1998), and decision-making in relation to performing or avoiding cardio-pulmonary resuscitation (Schultz, 1999). A major area of ethical concern for nurses identified in some of these studies was the limited level of involvement nurses were given in ethical decision-making in some settings (Bennett & Duke, 1995; Manias, 1998; Spence, 1998). Commitment to their role as advocates for their patients and to ensuring client needs and comfort were primary was also evident (Cartwright et al., 1997; McInerney & Seibold, 1995; Spence, 1998).

Ethical challenges in the wider context

Available research indicating the types of ethical dilemmas nurses encounter in Australia is limited. For that reason studies conducted in other countries, to gain an overview of the situations likely to pose such challenges, were also reviewed. It is acknowledged there are some variations in the health care systems between countries, and other factors such as cultural and social influences may also contribute to cross-national differences. Nevertheless, there is benefit in gaining an overview of the types of situations nurses have to deal with and to consider if there are significant similarities and differences between settings and countries.

Several studies have been conducted in the USA to identify the types of ethical issues and concerns nurses encounter in their practice. Two studies in particular deserve more detailed mention, the first because it was carried out over a nine year period so investigated beyond a single instance, and the second because it investigated nurses working in several types of clinical settings. Between 1984 and 1993, nurses (N=794) in a major Californian hospital were surveyed to identify the ethical issues they encountered during their practice (Omery, Henneman, Billet, Luna-Raines, & Brown-Saltzman, 1995). Pain relief/management was ranked highest as the most frequently identified ethical issue and this was consistent in each year of the survey. Other issues highly ranked by these nurses were: dealing with patients who were difficult; relationships between the patient, physician and nurse and the decision processes used; caring for noncompliant patients; and the cost to the patient of their care (Omery et al., 1995). The second study combined the results of a series of five smaller studies investigating nurses working in four specialised areas. Redman and Fry (2000) reported that the major causes of ethical conflict for the nurses were: conflict between beneficence and non-maleficence in relation to client treatment; decisions about initiating or discontinuing treatment, at times against the client's wishes; protection of client rights; lack of respect for client autonomy; conflicts related to institutional or health policy; and allocation of resources. Both studies identified that nurses often had to deal with ethical issues which had the capacity to impact on client welfare and comfort.

Other studies conducted in the USA indicate that many of the situations which cause nurses to be ethically challenged revolve around clients and the appropriateness of their treatment. Poor pain management (Omery et al., 1995; Raines, 2000), cost of treatment and access to care (Chally & Loriz, 1998; Gold et al., 1995; Omery et al., 1995), informed consent and decision-making processes (Chally & Loriz, 1998; Gold et al., 1995; Omery et al., 1995; Raines, 2000) and end of life care (Chally & Loriz, 1998; Dickenson, 1999; Raines, 2000) are some of the issue identified as causing moral concern. Additionally, nurses also have to deal with ethical problems arising between people (including patients, family members, doctors, and other nurses) (Chally & Loriz, 1998; Omery et al., 1995; Raines, 2000) and within organisations (Gold et al., 1995).

Similarly, studies conducted in other countries such as Israel (Wagner & Ronen, 1996), the Netherlands (van der Arend & Remmers-van den Hurk, 1999), Korea (Sung-Suk & Sung-Hee, 2000), and the United Kingdom (Dickenson, 1999) identify that nurses find themselves having to deal with ethical concerns related largely to what is happening to their patients. Some of the ethical problems are akin to those identified by nurses in the USA, and include issues such as decision-making processes (Dickenson, 1999; Sung-Suk & Sung-Hee, 2000; van der Arend & Remmers-van den Hurk, 1999; Wagner & Ronen, 1996), resource allocation (Dickenson, 1999; Wagner & Ronen, 1996), institutional organisation (van der Arend & Remmers-van den Hurk, 1999), and professional relationships (Sung-Suk & Sung-Hee, 2000; van der Arend & Remmers-van den Hurk, 1999). Others, in countries where regulations differ, also report concerns related to medical experimentation without consent, or even commercial organ trafficking (Sung-Suk & Sung-Hee, 2000).

It is apparent that whatever the setting or country, nurses report that issues which compromise client comfort, dignity, and autonomy are of highest concern. Problems to do with working relationships with other health care professionals, and challenges posed by the cost of treatment and allocation of resources are also ranked highly. As such, nurse often find themselves in situations where they need to mediate, rationalise, or explain, as well as having to personally live with their own, and others, choices and actions. However, some have questioned whether in fact nurses have the appropriate skills to both recognise and deal with the array of ethical challenges they encounter (Dierckx de Casterle, Grypdonck, Vuylsteke-Wauters, & Janssen, 1997; Gold et al., 1995). Further, even if nurses are acknowledged as moral agents possessing skills appropriate for ethical decision-making, whether or not they are given opportunity for their personal opinions and choices to be considered is open to debate (Holly, 1993; Penticuff, 1989; Sherblom, Shipps, & Sherblom, 1993; Spence, 1998).

Ethical reasoning and decision-making by nurses

Interest in the ethical reasoning processes used by nurses burgeoned in the 1980s and 1990s. An important impetus to this was the Kohlberg versus Gilligan debate. Two models of moral development, one proposed by Lawrence Kohlberg (1981), the other by Carol Gilligan (1982), were commonly referred to in discussions about the moral development of nurses, even though neither model developed from the study of nurses or indeed adults exclusively. Kohlberg (1981), who studied a group of boys over a 15 year period, identified there were six stages in moral development with movement from being morally undeveloped through to moral maturity. His model identified justice as the major basis for moral reasoning. Gilligan (1982; 1987) was critical of Kohlberg applying his theory to women when his study participants had all been males. She studied teenagers and women to identify if there were differences in the way the two genders reasoned ethically and concluded that women used a care focus, rather than the justice focus identified by Kohlberg.

Several nursing authors subsequently debated the merits or otherwise of the Kohlberg and Gilligan models, or contributed to the ongoing debate as to whether they contributed to better understanding the moral reasoning of nurses (Allmark, 1995; Challey, 1990; Clay et al., 1983; Dierckx de Casterle, Roelens, & Gastmans, 1998; Felton & Parson, 1987; Ketefian, 1989; Olsen, 1993; Omery, 1995; Parker, 1990; Pinch, 1996; Riesch, von Sadovsky, Norton, & Pridham, 2000). Additionally, a number of research studies were conducted using one or both of the models as a framework for, or background to, the research (Cady, 1991; Dierckx de Casterle, Grypdonck, & Vuylsteke-Wauters, 1997; Dierckx de Casterle, Grypdonck, Vuylsteke-Wauters et al., 1997; Dierckx de Casterle et al., 1996; Lipp, 1998; Lutzen & Nordin, 1995; Norberg & Uden, 1995; O'Connor, 1996; Wilson, 1991) The high proportion of females in nursing, and the profession's acceptance of care as being central, triggered much of this writing and research.

A review of the research studies reported above indicates there is no firm evidence to support that one model or the other is gender exclusive, or is used predominantly by nurses. Given the coverage the debate between the two models has already received in the literature, I will not add any further to it other than to

acknowledge they have both been found to be conceptually limited. Further, neither is empirically sufficient to explain the nature of human ethical reasoning. I believe both models contribute to discourse about moral reasoning, but suggest that neither, on their own, can give a completely adequate explanation about how adults, including nurses, reason about moral issues in everyday life. McAlpine (1996) alluded to this when she posed the question "is it not possible that each of the current theories are part of the truth with respect to morality?" (p. 124). Omery (1995) summed it up well when she wrote: "Arguments over which perspective – justice or care – is appropriate are not needed; instead, discussions are necessary on how nurses are to integrate and prioritize both justice and care in any given patient situation requiring moral reflection" (p. 9).

If anything is to be gained from reviewing nursing literature on the Kohlberg versus Gilligan debate it is to conclude that to simply categorise female nurses as users of a care perspective and male nurses as users of a justice perspective is inappropriate. The study by Lipp (1998) found that participants, when making ethical decisions, used both care and justice perspectives concurrently. That this exploratory study used a grounded theory approach makes a valuable contribution to the debate. Rather than a study design that hypothesised nurses would make decisions from a particular perspective, the grounded theory design allowed the results to emerge from the data without any preconceived expectations of the findings. The study supported the notion that nurses use both care and justice approaches and will not easily be forced into binary categories of either one or the other.

Nurses' involvement in ethical decision-making

If, when they are ethically challenged, nurses are to be involved in ethical decision-making, they first need to be able to recognise the ethical dimensions of a situation. There is evidence this does not always occur, which limits, and at times even precludes, their ability to make reasoned ethical decisions in relation to such situations. Gold et al. (1995), seeking to find out what ethical issues concerned nurses, reported that some of their participants actually failed to recognise the ethical nature of the decisions they made daily. This limited their ability to act on them and find appropriate solutions. Some nurses recognise the ethical components of problems

encountered only after probing (Turner, Marquis, & Burman, 1996). Even where there is recognition of ethical challenges, nurses sometimes choose to distance themselves, or limit their involvement in them, out of fear of the consequences or due to lack of time to reflect on the problems (C. Kelly, 1998).

Nurses in some settings are given limited opportunity to be involved in decision-making related to ethical concerns (Holly, 1993; Wilkes, White, & Tolley, 1993), even when they have the skills and willingness (Penticuff & Walden, 2000; Wurzbach, 1996). This can add to their moral burden. The opinion of nurses may be sought in some settings, but such involvement may be limited when compared to their participation in making clinical decisions (Spence, 1998). Even where opportunities for nurses to be involved in decision-making are available, they are not always in a position to act as they would choose in regard to the ethical dilemmas they encounter (Sherblom et al., 1993). There is also evidence that nurses at times make decisions that are in conflict with decisions made by doctors, resulting in further moral distress (Uden, Norberg, Lindseth, & Marhaug, 1992). Where opportunity is provided for collaborative decision-making, benefits include reduction in constraints to the chosen action, and enhanced communication between nurses, doctors, clients and families (Pike, 1991).

It is apparent that nurses may at times be constrained in their involvement in making decisions about ethically challenging situations. Where they do have opportunity to voice an opinion, their ability to act as they would choose may be jeopardised because of external constraints imposed on them. This can increase the personal stress they experience as a result of encountering ethical problems.

The influence of nursing on nurses' moral reasoning

There is evidence the nursing profession and work environment can influence the ongoing moral development of nurses, including the values to which they refer when reasoning through situations with ethical dimensions. This was supported in findings by B. Kelly (1998), using a grounded theory approach, where she examined second year nursing graduates in the USA as they adapted to "the 'real world' of hospital nursing" (p. 1134). The study found that new graduate nurses undergo

changes in their ethical values during the first two years of practice as registered nurses, especially in relation to their professional ethical values. Various outcomes from such alterations included assimilation into the values of the institution in which they practiced, finding appropriate support within the clinical environment they were working in, changing to another environment more supportive of the nurse's values, or leaving nursing altogether. Preserving moral integrity was found to be crucial to self and identity (B. Kelly, 1998).

Actual nursing experience can also impact on the moral development and reasoning processes of more experienced nurses, although this does not necessarily preclude the influence of personal attitudes and values continuing to play a part. Woods (1997) used a grounded theory approach to explain the circumstances surrounding moral decision making by experienced registered nurses. The study, conducted in New Zealand, involved eight participants whose post-registration experience ranged from four to over 20 years. The findings give a tentative indication that experienced nurses use personal, socio-cultural, and professionally learned values when making ethical decisions.

The role of personal values/beliefs in nurses' ethical reasoning and decisions

Values and beliefs are used by individuals to set ethical standards and are referred to by an individual when making ethical decisions (Bergland, 1998; Wreen, 1991). As such, situations where an individual's values or beliefs are questioned or compromised will very likely cause him or her to feel ethically challenged. Bergland (1998) points out that peoples' religious beliefs play a role in forming their values and these in turn can affect them in their professional work. She asserts "it would be artificial to try to have two moral or ethical standards – one religious standard for purely religious life, and one professional standard for professional work" (Bergland, 1998, p. 142). This stance has credibility when one views people as holistic beings made up of interdependent dimensions, including the spiritual dimension (Taylor, Lillis, & LeMone, 1997).

In situations where nurses can have input into decisions, personal values and beliefs may influence the ethical decisions they make while carrying out their

professional duties. Cusveller (1998) suggests that "underlying all motivation and moral awareness in nursing are the nurse's beliefs and values" (p. 271). He further stresses the importance of individual nurses being aware of their own beliefs and values and how these influence the care given and the decisions made.

Research findings provide evidence that while ethical decisions are often driven by patients' needs and concerns, other factors, including nurses' values and beliefs are also part of the process. Wurzbach (1996) found that nurses made very few ethical decisions themselves, as it was usually the client, family or doctor who made the choice. However, where nurses were involved in decision-making "some decisions were based on the nurses' own personal beliefs, religious beliefs or family upbringing" (Wurzbach, 1996, p. 262), although other factors such as government and institutional regulations, medical orders and the wishes of the client or family were also considered.

Smith (1996) found that when making ethical decisions nurses consider their own integrity along with other aspects such as the perspectives of others, various alternatives, the possible consequences, objectivity, and priority. The study found that a nurse's integrity includes both personal and professional aspects of his or her being and involves "thoughts, values, beliefs, ethical principles and moral reasoning, religion, knowledge, experience, conscience, emotions, and relationships with the patient and family (such as trust and rapport)" (Smith, 1996, p. 20).

The role personal beliefs can have in clinical decision-making were also identified in a study by Cassells and Redman (1989). They investigated the sources 858 American registered nurses, six months to one year following graduation, perceived had helped them in developing their abilities to make ethical decisions. Approximately two thirds of the nurses identified religious influence as a source. This was ranked second after "group discussion of ethical dilemmas with colleagues/peers" in the one year post-graduation group, and "family influence" (Cassells & Redman, 1989, p. 471) in the six month post-graduation group. Personal values and beliefs, it is apparent, were a major consideration when making ethical decisions, rather than a potential occasional influence.

Similar results were found in a smaller study of 52 registered nurses in the USA, by Berger, Seversen and Chvatal (1991). They explored the frequency with which particular ethical issues were encountered, how the nurses were affected by them, and what resources they used to clarify such issues. Although 97 per cent of respondents indicated other nurse colleagues assisted them with clarification of ethical issues, referring to one's own personal values was identified as an important strategy by 88 per cent of the study sample. When asked to rank the resources used "the majority indicated that they most frequently used their own personal values, followed by consultations with nursing colleagues, friends, administrators, and family" (Berger et al., 1991, p. 519). The authors point out that it is cause for concern if nurses mostly refer to their personal values when clarifying ethical issues in clinical nursing as this is not necessarily the most appropriate way to make decisions within the professional environment.

Results from a study of 745 nurses in Israel found they identified their families as the major influence on the development of their attitudes in relation to ethical issues. This was followed, in order, by "religion, life experience, education, work experience and the media" (Wagner & Ronen, 1996, p. 301). It is noted this identified influences that actually helped shape their attitudes, rather than factors that influenced their decision-making. Nevertheless, unless nurses are consciously aware of their personal attitudes and what impacts on them it is quite possible their personal views could influence their clinical decisions. Failure to take this into account can result in decisions being made which reflect a nurse's own moral stance rather than the needs of those in his or her care (Grundstein-Amado, 1993).

There may be occasions where nurses find they are so personally in conflict with something that is happening that they choose to conscientiously object. As such, they refuse to participate in activities where their personal values or beliefs are violated (Birch, 1998; Johnstone, 1999). Such action is recognised within the *Code of ethics for nurses in Australia* (ANCI, 1993) as acceptable where an individual nurse's reasoned personal stance would be compromised, as long as there is no danger to the client's welfare or life. There are examples of nurses being prepared to

conscientiously object in situations where they are challenged on "moral grounds or a combination of moral and religious grounds" (Birch, 1998, p. 31). This represents the extreme end of the continuum of how nurses may resolve moral dilemmas that challenge their personal values and beliefs.

It is evident that a nurse's personal values and beliefs can influence the views they hold, and the choices they make when ethical issues are encountered in the professional setting. Although research shows that other factors are also considered during the decision-making process, influence from personal views and preferences is integral, and at times dominant.

Rationale for the Current Study

The literature review indicates there is now strong acceptance that nurses regularly encounter situations with ethical components. Moreover, they have an obligation to carry out nursing activities in an ethical way. However, there are aspects related to dealing with ethical issues in nursing that remain largely unexplored. In particular, there is a need to investigate how nurses in Australia, working in clinical settings where different sets of values often prevail, deal with the experience of having their personal values and belief systems challenged by situations that arise in the course of their practice.

There is evidence that personal values and beliefs do play a key role, at least for some nurses, in their recognition of ethical challenges and in how they would prefer to resolve them. These personal values and beliefs often derive from family and religious upbringing and are referred to during ethical reasoning and decision-making. Professional education and experience do not replace these, although evidence indicates that nursing experiences and work colleagues can influence nurses at times to clarify or modify them. The health care environment is one where people from many and varied backgrounds come together, either as health care consumers or providers, and interact. Decisions need to be made, many of which have ethical components to them. If personal values and beliefs are referred to when such decisions are made the possibility exists that there will be repercussions on the values and beliefs of others affected by such decisions, especially if they are different.

Nurses encounter such situations because they often perform activities where decisions made by other health care colleagues or by health care clients determine, or impact on, what they do.

The challenge to personal values and beliefs of nurses has not been empirically investigated and hence is not really understood. The actual processes registered nurses in Australia use to deal with conflicts between their personal values and belief systems and what is happening in the work environment is currently unknown. The reasoning and decision-making processes used by nurses when confronted with ethical situations that are personally challenging requires study. It is the aim of this study to investigate this gap in nursing knowledge.

Summary

Organised nursing developed in the Christian era and the contributions made by nurses at that time were strongly motivated by their values and beliefs. Subsequently there were periods where nurses were of questionable moral character, forced to care for the sick rather than it being a chosen career. However, by the twentieth century much had improved. Now an understanding of ethics is considered an important component of a nurse's overall knowledge base. The benefit of including ethics education in undergraduate, postgraduate, and continuing education programs for nurses is strongly supported.

Findings from various studies have benefited nursing knowledge by alerting the profession to the types of ethical issues nurses may encounter in their practice, and in particular those which are likely to cause conflict and stress. When given opportunity to contribute to decision-making about ethically problematic issues, recognising this does not always occur in every setting, nurses consider various issues and values involved. There is evidence that no one preferred approach is used by nurses when making ethical decisions. Nor do they simply refer to either a care or justice perspective. Research findings indicate both the nursing profession and nursing experience have an effect on the moral development of nurses, although influences from their families and personal experiences also continue to play a role. Literature supports that the personal values and beliefs of nurses can influence their

ethical decision-making process in the professional setting. However, the psychosocial processes they use when their personal values and beliefs are challenged have not been empirically studied. The review of literature has provided rationale to carry out a study that investigates these processes.

In Chapter Three I describe the design of the study used to research these processes, and outline the various procedures used to conduct it.

Chapter 3

Methods and Procedures

I have found grounded theory to be useful when we want to learn how people manage their lives in the context of existing or potential health challenges and as such, is admirably suited to nursing enquiry. What is key in this process is learning the ways that people understand and deal with what has happened to them through time and in changing circumstances.

(Schreiber, 2001, p. 57)

Chapter overview

In this chapter I describe the procedures used to conduct this study. The research question and aims are outlined and the research design described. A brief summary of the historical development of the grounded theory method is provided and the reasons for utilising this method for the current study given. Procedures used to recruit participants and then to collect and analyse the data to generate a substantive theory are described. Finally, the ethical issues involved in the conduct of the study, and methods used to ensure scientific rigour, are outlined.

Research question

The research question for this study is: What are the psychosocial processes that can explain how registered nurses reason and make decisions when faced with ethical situations in the clinical setting that challenge their personal values and belief systems?

Aims of the study

The aims of this study were to:

1. investigate how registered nurses respond when they find themselves in situations where their personal values and beliefs are not congruent with what is happening;

2. identify the reasoning and decision-making processes registered nurses use when they encounter ethical situations in the clinical setting that challenge their personal values and belief systems;

3. generate a substantive theory that explains the psychosocial processes registered nurses use to reason and make decisions when faced with ethical situations in the clinical setting that challenge their personal values and belief systems.

Research design

Grounded theory is a qualitative research method used to develop theory that is grounded in data which have been systematically gathered and analysed during the study (Strauss & Corbin, 1994). Initially developed by Glaser and Strauss (1967) the method is used to inductively derive theory about social processes (Morse & Field, 1995). It offers a useful approach for nurse researchers who wish to investigate social-psychological processes and generate theoretical explanations of them (Chenitz & Swanson, 1986).

Grounded theory defined

Grounded theory refers to a particular method of performing data analysis during data collection, the fundamental purpose of which is to generate theory to aid in explaining human behaviour (Morse & Field, 1995). This method is used to generate new theory and understanding about a phenomenon, rather than test existing theory (Streubert Speziale & Carpenter, 2007). In the more traditional scientific research methods researchers approach studies with explicitly stated hypotheses which are then either verified or refuted (Battistutta & McDowell, 2005). The traditional methods search for new understanding by predicting outcomes, making objective observations in controlled environments, and testing theories (Schneider et al., 2003). In contrast, when using the grounded theory approach "A researcher does not begin a project with a preconceived theory in mind … Rather, the researcher begins with an area of study and allows the theory to emerge from the data" (Strauss & Corbin, 1998, p. 12). Further clarification of the difference between the grounded theory method and the more traditional scientific methods is provided by Hutchison (1993) who suggests that:

> A researcher using an existing theory approaches the problem from the top down (from theory to practice) rather than from the ground up (from practice to theory). Grounded theory employs an inductive, from-the-ground-up

approach using everyday behaviours or organizational patterns to generate theory. (pp. 183-184)

A theory which emerges using the grounded theory approach can thus be considered to have direct relevance because it has been developed from the world in which the phenomenon occur and from reality as the participants perceive it.

Historical development of grounded theory

Glaser and Strauss (1967) first published a description of the method in their co-authored book *The Discovery of Grounded Theory*. Their stated purposes for the book included an attempt to "strengthen the mandate for generating theory, to help provide a defense against doctrinaire approaches to verification, and to reawaken and broaden the picture of what sociologists can do with their time and efforts" (Glaser & Strauss, 1967, p. 7). A further aim of the book, emphasised by Strauss and Corbin (1994), was an attempt to improve the legitimacy of qualitative research which, in the 1960s, had low status because of the perception amongst researchers that it was not useful for verification.

Glaser and Strauss (1967) also stressed their text was intended to identify the "basic sociological activity" (p. 6) required to generate sociological theory and that only sociologists could do that. Although acknowledging other forms of investigation such as "description, ethnography, fact-finding, [and] verification" (p. 6) could be performed well by professionals in other disciplines, such activity was not suitable for deriving sociological theory. In fact, they emphasised that, in relation to the generation of sociological theory, "only sociologists are trained to want it, to look for it, and to generate it" (Glaser & Strauss, 1967, p. 7). Their point has merit when one considers that the generation of a theory is dependent on more than just raw data. Theory does not simply emerge from the data; it needs to be constructed by a researcher who has the necessary conceptual tools with which to accomplish the task. Nevertheless, grounded theory as a research method has not been confined to use only within the discipline of sociology. Many other disciplines, when studying human action and interaction, now make use of the approach (Strauss & Corbin, 1998). Social processes are not restricted to the discipline of sociology and there is a need for such processes to be studied within other disciplines by researchers who are

familiar with the environments in which they occur. Further, the study of some phenomena require a focus on psychological as well as sociological processes so it is difficult to argue its use should be restricted to those from the discipline of sociology (Holloway & Todres, 2003). However, any researchers who use the method need to ensure they have an understanding of social concepts and appropriate analytical skills if they are going to generate theory that is sound.

When Glaser and Strauss (1967) developed grounded theory, they were critical of the apparent overemphasis on obtaining facts and then using them to verify theory, an activity commonly used by sociologists of the time. They argued that, important as such activity was, there was a need to give more time and emphasis to the generation of theory rather than just focussing on its verification. By using comparative analysis, allowing for the systematic discovery of theory by the careful and in-depth examination of the data in the study, they contended that theory, grounded in the data, could be scientifically derived. The benefits obtained from theory generation are, according to Glaser and Strauss (1967) the same as those resulting from testing theory, with one addition. The fact that in grounded theory the generated theory is derived from the data rather than from assumptions results in "theory that 'fits or works'" (Glaser & Strauss, 1967, p. 30). They point out that:

> By "fit" we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by "work" we mean that they must be meaningfully relevant to and be able to explain the behavior under study. (Glaser & Strauss, 1967, p. 3)

The emphasis on theory emerging from the data, and being true, is clear.

Grounded theory can be used to develop either substantive or formal theory. Glaser and Strauss (1967) describe substantive theory as "that developed for a substantive, or empirical, area of sociological inquiry" (p.32), and formal theory as "that developed for a formal, or conceptual, area of sociological inquiry" (p. 32). Streubert Speziale and Carpenter (2007) suggest both substantive theory and formal theory are middle-range theories which, although more narrow than grand theories in their scope, are very useful in their ability to encompass concepts of reality in a way that can be empirically tested.

Although Glaser and Strauss are credited with being the developers of the grounded theory method in the 1960s, they subsequently parted company and eventually used varying approaches, particularly in relation to data analysis (Walker & Myrick, 2006). Stern (1994) identifies there are now, as a result, two methods that are fundamentally different. Glaser's method is one that remains focused only on the data, constantly asking, "What do we have here?" whereas Strauss asks the question at each word, "What if?" (Stern, 1994, p. 220). In summarising the differences in approach, Stern (1994) suggests "Strauss brings to bear every possible contingency that *could* relate to the data, whether it appears in the data or not. Glaser focuses his attention *on* the data to allow the data to tell their own story" (p. 220 emphasis in the original). Stern (1994) further reports Glaser has argued his method is fundamentally the original approach he and Strauss developed and Strauss has departed from that. There is general acknowledgment that Glaser has remained more faithful to the original form of grounded theory (Heath & Cowley, 2003; McCann & Clark, 2003; Stern, 1994; Walker & Myrick, 2006). Strauss, on the other hand, has pointed out that both he and the method have, through time and experience, evolved and such change is only natural. Such evolution should not be considered surprising, according to McCann and Clark (2003), who point out ongoing divergence in approach, over time, is also evident in other methodologies.

It is now commonly accepted there are two major approaches to grounded theory, each with a different epistemological underpinning. McCann and Clark (2003) point out the approach expounded by Glaser is guided by "critical realist ontology and [the] postpositivist paradigm" (p. 23). The approach developed by Strauss and Corbin "draws on social constructionist ontology and the poststructuralist paradigm, where reality cannot be known but can be interpreted" (McCann & Clark, 2003, p. 23). Strauss and Corbin's approach also has a broader field focus with consideration being given to both the cultural scene and the participants' socially constructed reality, whereas Glaser's approach emphasises the "socially constructed world of participants" (McCann & Clark, 2003, p. 24).

Differences in approach are also acknowledged by Heath and Cowley (2003) who identify that originally analysis in grounded theory was recognised to have two

levels, with the initial level generating all possible categories, followed by the integration of these categories to a reduced number. Strauss and Corbin (1990) subsequently recommended three steps, these being open coding, axial coding and selective coding. Glaser (1978) has also further developed the grounded theory approach since its inception. However, his method of analysis continues to have two major levels, substantive coding and theoretical coding.

It must be acknowledged that although the differences between the two approaches are regularly discussed, there are some commonalities. Both approaches emphasise the generation of a theory that is grounded in the data and they have many characteristics in common (McCann & Clark, 2003). Although within the common characteristics there are some differences, "they relate mainly to the degree to which any element is adopted, rather than the substance of the element" (McCann & Clark, 2003, p. 22). The choice as to which approach a researcher selects can depend on various factors including the focus of the study and the philosophical underpinning of the phenomenon being investigated. Further, there are some researchers who will prefer the paradigm model with more detailed guidelines provided for data analysis in the approach developed by Strauss and Corbin (1998). This differs from the Glaserian approach which has more flexibility and is guided more by the participants and their reality rather than set out procedures (McCann & Clark, 2003). Whichever of the two approaches a researcher chooses to use, Stern (1994) strongly urges those inexperienced with the method to ensure they find a good mentor to give them appropriate guidance.

The approach to data analysis put forward by Strauss and Corbin (1998) offers the researcher a framework that gives focus on conditions, actions/interactions, and consequences, particularly during axial coding. I was drawn to choosing this approach because the paradigm made logical sense when examining a process. Additionally, I found the detailed description of the three-level analysis to be informative and detailed, and thus a helpful guide. In so doing, I acknowledge that the grounded theory method is not a simple linear or sequential process (Morse & Field, 1995; Strauss & Corbin, 1998). Although Strauss and Corbin (1998) describe three levels in their coding process, namely open, axial and selective coding, it must be

understood they do not occur as separate entities that necessarily occur one after the other. Rather, the levels are closely linked, although one is usually at the forefront at a given point in analysis. The constant comparative method requires the researcher to constantly compare data with all other data at every level of analysis (Schreiber, 2001), and this requires a "process [that] is both hierarchical and recursive" (Morse & Field, 1995, p. 157). The three levels of coding described by Strauss and Corbin (1998) provided me with helpful guidance as I navigated this process.

Grounded theory continues to evolve (Annells, 1996, 1997a, 1997b; Charmaz, 2000; McCann & Clark, 2003; McDonald & Schreiber, 2001; Mills, Bonner, & Francis, 2006b) and questions about various issues related to the method continue to be discussed. For example, there has been on-going debate as to which of the two data analysis approaches (Glaser versus Strauss and Corbin) is more pragmatically conducive to theory development (Heath & Cowley, 2003; LaRossa, 2005; Lomborg & Kirkevold, 2003; McCallin, 2003; McCann & Clark, 2003; Walker & Myrick, 2006). It is apparent from the discussion that individual researchers should determine for themselves the relative merits of each approach. There is benefit in familiarising themselves with both the similarities and differences between the two procedures in order to "select the method that best suits their cognitive style" (Heath & Cowley, 2003, p. 141).

Recent attention has also been given to the constructivist nature of grounded theory (Annells, 1996; Charmaz, 1990, 2000; Lomborg & Kirkevold, 2003; Mills, Bonner, & Francis, 2006a; Mills et al., 2006b). Mills et al. (2006b) suggest that Strauss and Corbin initiated its development with Charmaz making further contribution. Charmaz (2000) explains that "A constructivist grounded theory distinguishes between the real and the true. The constructivist approach does not seek truth – single, universal, and lasting. Still, it remains realist because it addresses human realities and assumes the existence of real worlds" (p. 523). When constructing theory the researcher "constructs an image of *a* reality, not *the* reality" (Charmaz, 2000, p. 523 emphasis in the original). She argues that constructivist grounded theory moves the method to "a middle ground between postmodernism and positivism" (Charmaz, 2000, p. 510). The interaction between the researcher/s and

participant/s is considered important in the approach and it is acknowledged they mutually contribute, as coconstructors, to the construction of meaning from the data (Charmaz, 2000; Mills et al., 2006a). Charmaz (2000) points out that in the past there has been a tendency for the authors of grounded theory to be too detached from the participant data and she encourages closer interaction with it by giving more focus to the actual words when analysing. This is more likely to "communicate how the participants construct their worlds" (Mills et al., 2006b, p. 7).

Glaser (2002) takes issue with Charmaz's view that constructivist grounded theory has an important contribution to make as a research method, describing it as unnecessary if data analysis has been done appropriately. He asserts that Charmaz's constructivist grounded theory results in giving "careful, full, voice and meaning description of the participant's story, in short a QDA [qualitative data analysis] DESCRIPTION" (Glaser, 2002, para. 26 emphasis in the original). Given grounded theory was developed to generate conceptual theory, he argues that the constructivist approach is irrelevant and her re-modelling is an "erosion of pure GT [grounded theory]" (Glaser, 2002, para. 39). Constructivist grounded theory, Glaser (2002) points out, gives focus to describing, rather than conceptually explaining what is going on, and risks diluting participants' concerns due to researchers forcing interpretations of the data instead of paying attention to what the participants are actually revealing.

I would argue there is a place for constructivist grounded theory. Mills et al. (2006b) suggest "researchers must choose a research paradigm that is congruent with their beliefs about the nature of reality" (p. 2). The constructivist paradigm recognises there are multiple realities, and that the personal experiences of participants and the researcher/s should be acknowledged (Hussain & Cochrane, 2003; Mills et al., 2006a, 2006b). Giving consideration to these multiple experiences allows participants and researcher/s to be coconstructors, with the researcher's knowledge and reality accepted as something "to be managed and not an intrusion to be ignored" (Hussain & Cochrane, 2003, p. 27), while ensuring that the generated theory continually maintains "the participants' presence throughout" (Mills et al., 2006b, p. 7). This is an approach that accepts a relativist ontology as opposed to a realist ontology

(Chamberlain, Stevens, & Lyons, 1997). Utilising a constructivist paradigm allows the grounded theory researcher who has a relativist stance to give validity to the experiences and beliefs of all those participating in the study without being controlled or constrained by accepted norms or contexts (Hussain & Cochrane, 2003; Mills et al., 2006b). This, I would argue, is pertinent when investigating the experience of having personal values and belief systems challenged.

Grounded theory research in nursing

Sociologists initially developed and used the grounded theory method, but its use as a research approach has not been limited to that group. Other disciplines have since found it a constructive approach to use when exploring human experience, particularly where those experiences involve human interactions and the associated social-psychological processes (Chenitz & Swanson, 1986; Streubert Speziale & Carpenter, 2007). Strauss and Corbin (1994) acknowledge its use by researchers in various disciplines including psychology, anthropology, education, social work, and nursing. Benoliel, a nurse sociologist who studied under Glaser and Strauss in the 1960s, is acknowledged as the first nurse to use the method (Hutchinson, 1993). During the 1970s several nurses undertook training in grounded theory and have subsequently made major contributions to nursing research through their various publications about the method. Deserving particular mention for their work in this area are Chenitz, Hutchison, Stern, and Swanson. The discipline of nursing with its inclusion of various, and at times complex, human interactions between health care professionals and health care clients, has made increasing use of grounded theory over the past three decades (Benoliel, 1996).

Rationale for use of the grounded theory approach in this study

When investigating the actual lived experiences of individuals, it is difficult to extract detailed information regarding what they think and feel about such experiences, and the meaning of them, by use of statistical, quantitative methods. Qualitative research methods are more appropriate when studying problems focused on "research about person's lives, lived experiences, behaviors, emotions, and feelings as well about organizational functioning, social movements, cultural

phenomena, and interactions between nations" (Strauss & Corbin, 1998, p. 11). Various qualitative research methods are available to researchers and the actual research question being investigated is what should guide the researcher in the selection of the appropriate method to use (Holloway & Wheeler, 1995; Schneider et al., 2003; Streubert Speziale & Carpenter, 2007).

There are characteristics common to the various qualitative research methods. These include acceptance "that multiple realities exist and create meaning for the individuals studied" (Streubert Speziale & Carpenter, 2007, p. 21). This can result in multiple truths because not all individuals experience a phenomenon identically. In order to gain understanding of the phenomenon being explored these various perspectives need to be examined. Participants are studied in their natural context as much as possible and "commitment to the participants' viewpoints" (Streubert Speziale & Carpenter, 2007, p. 22) is expected. When reporting qualitative data, participant narratives are used, and there is acknowledgment that the researcher also plays a participatory role in the research process.

However, there are also important differences in the various qualitative approaches and qualitative researchers need to consider these carefully in order to select the method appropriate to the particular research question they wish to explore. Phenomenology is a qualitative method used to "describe particular phenomena, or the appearance of things, as lived experience" (Streubert Speziale & Carpenter, 2007, p. 76). Its goal is to gain understanding of a particular phenomenon by investigating individuals who have lived that experience. Such studies provide "descriptions that are rich and full and interpretations that illuminate what it means to be a person in that life-world" (Schneider et al., 2003, p. 197). If the purpose of my research study was to investigate the actual experience of nurses having personal beliefs and values challenged, rather than the processes used to deal with such experiences, phenomenology would have been the appropriate research method to use. Ethnography is a qualitative method used to gain understanding of "the behaviour of a group of people in the context of its culture" (Schneider et al., 2003, p. 180). Had the purpose of my research study been to explore the development of patterns used to deal with challenges to personal beliefs and values, and their meanings, used by

nurses from a particular ethnic or cultural group, or working in a specific specialty area of nursing, ethnography would have been an appropriate methodology to use. A feminist approach to research is used to "illuminate, explicate and validate women's experiences, concerns and ways of being, and to challenge structures that marginalise and oppress women" (Schneider et al., 2003, p. 210). If, in my research study, I had wanted to focus on exploring the experience of female nurses when they deal with ethically challenging situations, a feminist approach could have been appropriate. Alternately, a critical approach to social enquiry would have been appropriate if I was investigating constraints nurses may experience to their ability to deal with ethically challenging situations because of oppressive features within their work environment (Schneider et al., 2003).

None of the qualitative methods just described were suitable for the research question which guided my study. The focus of the study was on the psychosocial processes used by nurses when faced with ethical situations that challenged their personal values and belief systems, so use of a qualitative method to investigate the phenomenon was appropriate. Because the aim of the study was to identify and describe these processes, rather than just the experience of being challenged by them, the grounded theory approach was considered the most appropriate method to use. This method allows the development of a substantive theory, grounded in the data, to explain the processes used by registered nurses when their personal values and belief systems are challenged by ethical situations in the clinical setting.

Application of grounded theory methods to this study

The various procedures used in the grounded theory approach were applied to this current study. How this specifically occurred is now described in detail.

The research question

Grounded theory studies are guided by a research question (or questions). The central research question, which in grounded theory focuses on a particular social process, needs to clearly identify the phenomenon being investigated. Because of the emerging nature of the grounded theory approach, the researcher commences with a research question that will identify the focus of the study, but the question is likely to

undergo refinement as the data are collected and analysed. Therefore the initial question needs to be sufficiently broad to allow modification as required during the study, but with adequate focus to appropriately guide the study (Streubert Speziale & Carpenter, 2007). Strauss and Corbin (1998) point out that the "research question begins as an open and broad one, but not so open, of course, as to allow for the entire universe of possibilities. On the other hand, it is not so narrow and focused that it excludes discovery" (p. 41).

Initially my research question for the study was: What are the psychosocial processes that can explain how newly registered nurses reason and make decisions when faced with ethical situations in the clinical setting that challenge their personal values and belief systems? The definition of 'newly registered nurses' in this context was registered nurses who had completed their formal education and obtained nursing registration within the previous two years.

Recruitment for the study using the eligibility criteria of 'newly registered nurses' subsequently proved to be extremely challenging, with very few responses received from potential eligible participants. A pragmatic response to the lack of volunteers for the study resulted in the eligibility criteria being changed to any registered nurses, rather than it being limited to only 'newly' registered nurses.

Recruitment of participants

Participants in a grounded theory study need to have experience of the phenomenon under investigation. It is common therefore to use convenience, purposive or snowballing sampling techniques (Schneider et al., 2003). Purposive and snowballing sampling were used to recruit participants in the current study.

Once ethical clearance was obtained I sought the assistance of the Directors of the Nurse Transitional Support Programs in two area health regions and a major acute care hospital to assist with recruitment. In line with the approved protocols of the study, a written request was sent to these three individuals requesting they assist with facilitating participant recruitment by bringing the study to the attention of newly registered nurses employed in their area health service or institution. Letters of

introduction, describing the study, were given to the facilitators to use as a means of presenting the study to suitable individuals (see Appendix I). Potential participants, who indicated an interest in the study by making contact with me by telephone, email or posted letter, were then sent an information package containing a more detailed explanation of the study (see Appendix II & Appendix III). The content of these more detailed information letters was slightly different for one health care area due to requirements of the ethics committee overseeing that particular area health region, but this did not have any effect on actual recruiting procedures. Also included in the package was an invitation to return a response form (see Appendix IV) on which potential participants could indicate their interest in being involved, their willingness to meet with the researcher, and a contact phone number so that an appointment could be arranged. A stamped, addressed envelope included in the information package provided a convenient method for sending the information about interest in participation and contact details back to me. A further method of recruitment used was to suggest to participants, at the conclusion of their interview, that they could bring the study to the attention of nursing colleagues who met the inclusion criteria and who they considered might be interested in participating. This was completely voluntary on the part of the participants.

Recruitment using the above processes proved to have poor success. Over the first few months only one participant was recruited. To further help with the process of recruitment two of the Directors of the Nurse Transitional Support Programs invited me to attend scheduled education days for new registered nurses in their facilities, allowing me a few minutes to briefly explain the study and give my contact details to these groups. This occurred only in the context of a group and no approach was made on a one-to-one basis with any individual who fitted the criteria for eligibility in the study. I met with one group of newly registered nurses, during their scheduled education day, at the beginning of my recruitment process and then eight months later with four separate groups over a period of three months.

Within six months of commencing data collection I had only recruited and interviewed two participants. On reflection, and following consultation with nursing colleagues, I concluded the recruitment problems may relate to recent nurse graduates

lacking confidence to discuss ethically challenging experiences with an experienced nurse. Furthermore, new registered nurses with limited experience may have difficulty identifying and articulating ethical dimensions of their nursing practice. Therefore I made the decision to open the study up to any registered nurses rather than restricting it to 'newly' registered nurses. The other eligibility criteria remained unchanged. Approval for this modification was sought from all of the appropriate ethics committees, and granted. The study was then advertised through staff newsletters in the area health regions and institutions and by placing advertisements on various staff noticeboards. Effectiveness of the change in eligibility criteria was immediately obvious with four potential participants making contact with me within just a few days of the advertising commencing.

Although the expansion of the eligibility criteria to include any registered nurses improved recruitment, the process of recruiting a sufficient number of participants to attain theoretical saturation still proved to be challenging, despite multiple advertising. During the process of data collection I was working full time so time commitment to the study was limited. As it transpired data collection occurred over a total of 38 months, between 2001 and 2004. A major advantage of having a protracted recruitment phase was that it allowed time for verbatim transcription of interviews and concurrent data analysis to occur between many of the interviews. In line with the grounded theory approach this allowed me to become very familiar with the data from each interview before proceeding to the next. This enhanced opportunity to allow the data to continuously inform the focus of ongoing data collection.

Profile of the participants

Twenty-three participants volunteered to be involved in this study. They were recruited from metropolitan and regional areas of New South Wales. To help preserve their anonymity, a brief overview of their group profile is provided, rather than a detailed description of individual participants.

Nineteen (83%) of the participants were women, and four (17%) were men. Their ages ranged from 30 to 58 years, with an average age of 44 years. Thirteen of

the participants had worked prior to commencing nursing, mostly in jobs that did not require formal qualifications, for example shop assistants, farming, and process work. The period of time that had elapsed since completing their initial nursing qualification ranged from eight months to 38 years. Three of the participants fitted the original criteria of being within two years of completing their formal training to become a registered nurse. Ten of the participants had completed their initial nursing qualification at a tertiary institution. Of the 13 who completed their initial qualification in a hospital-based certificate program, nine had proceeded on to further study and completed postgraduate programs at institutions of higher education.

A summary of the profile of the participants is provided in Table 3.1. They are not listed in the order in which they were interviewed; rather they are presented in random order as a means of adding to the protection of their identity.

Table 3.1 Summary of the profile of the participants

Gender	Age (years)	Time (years) since completing initial nursing qualification	Types of institutions where nursing studies were undertaken
Female	58	30+	Hospital and Tertiary Institution
Female	44	14	Tertiary Institution
Female	38	18	Tertiary Institution
Male	55	35	Hospital and Tertiary Institution
Female	30	8 months	Tertiary Institution
Female	39	18.5	Hospital
Male	32	9	Tertiary Institution
Female	55	34+	Hospital
Female	46	25	Hospital and Tertiary Institution
Female	43	22	Hospital
Female	40	2	Tertiary Institution
Female	49	27	Hospital
Male	58	38	Hospital and Tertiary Institution
Female	38	15	Tertiary Institution
Female	38	1	Tertiary Institution
Female	55	34	Hospital and Tertiary Institution
Male	43	3	Hospital and Tertiary Institution
Female	31	6.5	Tertiary Institution
Female	46	29	Hospital and Tertiary Institution
Female	41	20	Hospital and Tertiary Institution
Female	50	6.5	Tertiary Institution
Female	52	27	Tertiary Institution
Female	40	20	Hospital and Tertiary Institution

The participants had worked in a large range of clinical areas with representatives from both acute care and long-term facilities. The specialty areas in which participants had worked included medical nursing, surgical nursing (with several specialties identified), midwifery, paediatrics, oncology, palliative care, accident and emergency, mental health nursing, operating theatre nursing, and

community nursing. Some of the participants were employed by the public health system, others by private institutions or facilities. Additionally some participants had worked, or were currently working, in nursing areas that were not clinically focused such as administration, education and research.

Data collection

The major data collection method used in this study was semi-structured, in-depth, audio-taped interviews with individual participants, a method commonly utilised in grounded theory research (Schneider et al., 2003; Streubert Speziale & Carpenter, 2007). Immediately prior to commencing each interview the participants were reminded of the contents of the detailed information letter and were then requested to sign a consent form (see Appendix V & Appendix VI) to indicate their willingness to participate in the study. The ethics committee of one of the area health regions required the signature of a witness to be included on the consent form, along with additional information to be included, whereas the consent form for the other regions did not require such detail. Hence there was a need to have two different consent forms. The interviews focused on asking the participants to: (1) provide an overview of their personal values and/or belief system; (2) identify incidents they had faced in their work as a registered nurse that had challenged their personal values and/or belief systems; and (3) discuss how they dealt with this challenge. The questions posed during the interview generally followed the outline of questions in the 'Interview Schedule for Participants' (see Appendix VII), particularly in the initial stage of data collection. However, in line with the grounded theory method where data collection and analysis guide the ongoing process of the study, as it progressed there were modifications made to the questions as categories were developed. Basic demographic data (see Appendix VIII) were collected from each participant at the conclusion of the interview to allow a demographic overview of the sample group.

The interviews occurred in a variety of venues with the participants given the opportunity to choose a location that would be convenient and suitable to them. Some of the participants chose to be interviewed in their homes, some in their workplace where they had a private and undisturbed room available, some at my workplace, and a few chose a setting that was independent of both of us. All venues provided privacy.

On occasions, during the interview process, when I became conscious I was forming an opinion related to the information a participant was sharing, I ensured I did not express my stance (Mallory, 2001). Additionally I recorded such incidents as memos when the interviews concluded to ensure I remained aware of any judgements I made so I could avoid them influencing the way I analysed and interpreted the data (Strauss & Corbin, 1998).

The interviews ranged between 25 minutes and 90 minutes. The majority lasted for 45 minutes to one hour, the average time being 50 minutes. None of the participants became visibly upset during the course of the interviews. A few of them, at the conclusion of the session, expressed gratitude to me for the opportunity to talk about the issues and made spontaneous comments about the importance of such research. An information sheet (see Appendix IX) listing various organisations that could be contacted if a participant, on reflection, determined he or she would like to follow through with any issues raised during the interview was given to each participant at the conclusion of the process.

A second method of data collection involved each participant being given one of two clinical vignettes (see Appendix X & Appendix XI) outlining a hypothetical clinical scenario of an ethical situation nurses could face in the course of their practice. One vignette focused on a situation involving a nurse objecting to having to care for a woman undergoing a termination of pregnancy because the foetus had Down syndrome. Soon after being informed the allocation of patients could not be re-arranged the nurse complained of a stress-induced migraine and left work for the day. The other vignette involved a nurse caring for a patient who communicated he did not want lifesaving treatment given and wanted to just be allowed to die. Subsequently, when the patient was no longer able to communicate, his family insisted on life-saving measures because they wanted everything done for the man, irrespective of the cost. This caused distress to the nurse who had witnessed the patient communicate he just wanted to be allowed to die and had reported that information to the doctor. The vignettes included a mix of ethical, clinical, and interpersonal issues reflecting everyday issues for nurses, although the actual situations in which they occur may

differ. Respondents were given opportunity to comment in terms of socially expected professional behaviour, but to also include more personal views and reactions.

Participants were requested to take a copy of a vignette away with them and to return their responses to me, in the stamped, addressed envelope provided, within the next one to two weeks. The vignettes were provided in hard copy and electronic (3½ floppy disk) mode to allow participants to choose their preferred method of writing the responses. A degree of anonymity was provided in this part of the study since the participants were not required to include their names on the response forms, and in fact they were encouraged to keep the feedback anonymous. It was anticipated the participants would be more open with their responses if they were not required to identify themselves. I made no attempt to match any returned response with the participant who returned it. Given the timing of several interviews and when the responses were received it could have been possible to identify some of the respondents. However, I actively ensured no such matching occurred by collecting all responses before analysing them in detail. The returned responses were not filed in any particular order so when I subsequently analysed them it was not possible to clearly identify which participant had completed a particular response. Two weeks after each participant was interviewed I sent a general follow-up letter (see Appendix XII) thanking them for their participation, acknowledging return of vignette responses, and inviting those who had not yet returned them to do so.

Two vignettes were used to allow a wider range of ethical issues to be canvassed. Additionally, it reduced the chance that participants would share a vignette with other nurses recruited at a later date and who may therefore have provided responses reflecting others' views rather than their own. Each participant was requested to respond to only one vignette, rather than two, because it was anticipated that would make the activity less arduous and therefore increase the return rate. Fifteen participants (65%) returned vignette responses with six responding to vignette 1 and nine to vignette 2. Five participants, during their interviews, spontaneously spoke about how they would deal with situations where they were caring for clients undergoing an abortion. This additional data from the interviews

supplemented the data from vignette 1, helping diminish any limitation the reduced response rate to that particular vignette may have incurred.

In keeping with the grounded theory approach, literature was also used as data. As I identified concepts from the interview and vignette data, I accessed relevant literature as data to make comparisons, particularly in relation to the properties and dimensions of the concepts (Strauss & Corbin, 1998). Additionally, reports from related research studies were utilised while data analysis was being conducted to assist in the process of confirming findings and in identifying discrepancies that indicated the need to seek further information (Strauss & Corbin, 1998).

Observation is a data collection strategy commonly included in grounded theory studies (Streubert Speziale & Carpenter, 2007), but it was not utilised in the current study. The focus of the study was not on how nurses talk about ethical issues, or communicate with others about being ethically challenged. Rather, it was on how they reason and decide and that is a subjective, internal process which is not amenable to observation. Little insight can be gained into the decision-making processes a nurse goes through in relation to ethical conflicts by observing the individual in the clinical setting. Such information can be more effectively gathered by interviewing nurses and asking them to outline the reasoning processes they employ. Additionally, it would be very difficult to time observations to occur when ethically challenging situations might be encountered.

The number of participants used in a grounded theory study, and the exact methods of data collection are not finalised at the commencement of the study. Rather, theoretical sampling is employed, a process "whereby the analyst jointly collects, codes, and analyzes his [sic] data and decides what data to collect next and where to find them, in order to develop his [sic] theory as it emerges" (Glaser & Strauss, 1967, p. 45). It is a method where the theory, as it evolves, controls the process of collecting further data (Strauss & Corbin, 1998), including the final number of participants recruited. Although the number of participants is ultimately determined by the achievement of saturation, Morse and Field (1995) indicate that

grounded theory studies typically have a sample size of 30 to 50. Further clarification has been provided by Morse (2000) who points out that when data is richer, as is usually the case with unstructured interviews as opposed to semistructured interviews, data saturation is likely to occur with fewer interviews. She suggests that 20-30 participants may be sufficient, particularly if interviews are unstructured and participants are interviewed multiple times. Other factors such as the scope and design of the study and topic being studied also need to be considered. Polit, Beck and Hungler (2001) report a range of 20 to 50 informants as being typical for grounded theory studies.

Consistent with the grounded theory method, I carried out data collection and analysis simultaneously (Glaser & Strauss, 1967; Schreiber, 2001). This continued until saturation was achieved, which, according to Glaser and Strauss (1967), "means that no additional data are being found whereby the sociologist can develop properties of the category" (p. 61). Strauss and Corbin (1998) suggest saturation of each category must be achieved, and can only occur if there is no new data emerging for a particular category, the properties and dimensions of each category are well developed with variation demonstrated, and there is establishment and validation of the relationships between the categories. Failure to do so for every category will result in a theory that is poorly balanced, with insufficient depth and precision. It was evident in the current study that theoretical saturation had occurred when data had been collected and analysed from 23 participants.

Data analysis

Data analysis in the grounded theory approach is conducted using a method called constant comparative analysis. Described by Glaser and Strauss (1967), it is designed to generate "a theory that is integrated, consistent, plausible, close to the data – and at the same time is in a form clear enough to be readily, if only partially, operationalized for testing in quantitative research" (p. 103). Strauss and Corbin (1998) point out that comparative analysis is regularly used in research in the social sciences, however the nature of comparative analysis used in grounded theory has some unique features. In summary, it is a process of comparing "incident with

incident, incident with category, and, finally, category with category or construct with construct" (Hutchinson, 1993, p. 210).

The responses from the vignettes were initially analysed using content analysis (Hsieh & Shannon, 2005; Polit et al., 2001). This involved "analysis of the content of the … data to identify prominent themes and patterns among the themes" (Polit et al., 2001, p. 394). Data from the interviews were analysed using constant comparative analysis (Strauss & Corbin, 1998). Following each interview, the tapes were transcribed verbatim to allow the data to be read and organised. I chose to do the transcribing myself, as much as possible, because I found this enhanced the process of immersing myself in the data (Schneider et al., 2003). Time constraints towards the end of data collection meant I sought assistance with the transcribing of three of the interviews. However, I edited these transcriptions, a process that gave me useful initial exposure to the data. The transcriber who provided me with assistance was the same individual each time and confidentiality of the material was assured. A document (see Appendix XIII) was signed by the transcriber to this effect. The data were managed and organised during much of the analysis process with the assistance of the computer program NVivo (Qualitative Solutions and Research, 1999), and then with NVivo 2 (Qualitative Solutions and Research, 2002) following the release of the upgraded edition.

Constant comparative analysis, using the three procedures of open coding, axial coding and selective coding as outlined by Strauss and Corbin (1998) was used to analyse the data obtained in the interviews. Data analysis commenced with the first interview transcript. I read it through line-by-line, identifying codes as they became apparent. This is the process of open coding in which:

> data are broken down into discrete parts, closely examined, and compared for similarities and differences. Events, happenings, objects, and actions/interactions that are found to be conceptually similar in nature or related in meaning are grouped under more abstract concepts termed "categories". Closely examining data for both differences and similarities allows for fine discrimination and differentiation among categories. (Strauss & Corbin, 1998, p. 102)

A category, in this context, is a phenomenon that has significance to the respondents in the study, and may be a problem, issue, event, or happening.

While open coding was occurring, I concurrently began the process of axial coding which is used to relate "categories to subcategories along the lines of their properties and dimensions" (Strauss & Corbin, 1998, p. 124). It is a process used to link categories with each other and involves an examination as to how various categories relate to each other, "commonly referred to as 'hypotheses'" (Strauss & Corbin, 1998, p. 103). These hypotheses are based on hunches the researcher has about the conceptual relationships and includes the seeking out of negative cases. Although they need to initially be considered as untested suggestions, as the study progresses particular relationships can be verified (Glaser & Strauss, 1967). This involved carefully studying all the data that were linked to a particular category to clearly identify the category's dimensions and properties.

By the time I had completed this process on 11 transcripts I had a total of 276 codes. At this stage I made a decision to commence collapsing the codes down and to start the process of determining the emerging categories (Strauss & Corbin, 1998). Through a series of several steps, mainly by combining codes which appeared to have major similarities to a labelled category, I collapsed the codes down until I had 16 categories.

The advantage of using the NVivo computer program was it allowed the data from the various transcripts allocated to each of the categories to be isolated to that category. This assisted the process of comparing data from each transcript with similar data from every other transcript. It was apparent by this stage there were certain patterns and themes beginning to emerge, but data saturation was not yet evident. Data collection with concurrent analysis continued with the established categories helping to guide the coding process, but not being allowed to limit it. By the time 16 transcripts had been analysed I had identified a further 3 categories, giving a total of 20 by this stage of analysis (see Appendix XIV). No further categories were identified by the completion of open coding of all 23 transcripts.

Included in the 20 categories was one titled 'Currently Uncoded', which contained data I considered were not relevant to the focus of the study. As analysis proceeded I was able to regularly review the data in this category to determine its relevance on an ongoing basis and incorporate it into the relevant data if I determined there was any change in its status. The total amount of data in this category remained very minimal and did not become relevant to the study.

When I had collapsed the codes down, initially to 16 categories, and then subsequently built up to 19 (20 including 'Currently Uncoded'), I followed a process of listing pertinent coded data from each participant that fitted into a specific category (see Appendix XV). This approach enabled me to determine which categories had a significant amount of data supporting them, and which ones did not. Further, it enabled me to identify apparent gaps in the data, particularly where there might have been no data from a specific participant. This alerted me to review the data from that participant to determine if I might have missed something during analysis.

In addition, I examined the conditions, actions/interactions, and consequences associated with each category (Strauss & Corbin, 1998). This is a framework which, when investigating process, helps the researcher seek insight into the conditions in which the phenomena occur, the responses made when these conditions occur, and the outcomes of these actions. Researchers are, however, cautioned not to adhere too rigidly to the paradigm when coding because some data may fit more than one of the three perspectives and so they need to avoid taking a simplistic cause and effect perspective.

During this process I was also able to start determining how some of the categories linked with other categories. Writing memos about emerging ideas and concepts was an important part of this procedure, as it enabled me to keep a record of hunches, questions, identified patterns, and decisions made about the data (Charmaz, 1990, 2000; Hutchinson, 1993; Strauss & Corbin, 1998). During axial coding I re-named some of the identified categories once I had a clearer understanding of what the data in them were actually saying. Additionally, I found some categories were in fact sub-categories of other categories and was therefore able to do some merging. It

was apparent at this stage that theoretical saturation had occurred in the data from 23 participants so no further recruitment was attempted. I determined saturation had occurred because no new categories were emerging and "no new properties, dimensions, conditions, actions/interactions, or consequences" (Strauss & Corbin, 1998, p. 136) were evident in the collected data.

Over a period of several weeks, I spent time immersed in the data to ensure no important data had been missed. This involved carefully working through all of the data supporting each of the categories. This process was not without its frustrations and there were times when I questioned my ability to complete the project. During these moments I reassured myself with a comment by Hutchinson (1993) who stated: "During the process of grounded theory generation, the researcher experiences alternating periods of confusion and enlightenment. Recognizing this fact enables the researcher to approach realistically this difficult but exciting method of research" (p. 206). I also spent time listening to each of the interview tapes as I re-read the transcripts to ensure I had also captured the participants' stories as wholes, rather than limiting my understanding of the data by focussing on the smaller sections of data in each category. It was during this process the core category emerged and I was confident it satisfied the criteria outlined by Strauss and Corbin (1998) for determining a central category.

Strauss and Corbin (1998) point out it is possible that an existing category from data analysis may be the core category. Alternatively, it may not be captured completely by the existing terms, requiring a new term or phrase to label it. The latter was the situation in this study. The core category was not one of the 20 categories I had listed at the conclusion of open coding. Rather, data for it were embedded particularly in the categories I had titled, 'Causes of Conflict/Challenges', 'Decision-making Process', 'Ethical Values', and 'Personal and Professional Link'. It was during the process of axial coding, while determining how various categories linked with each other and patterns began to emerge, that the core category became obvious. It became clear to me following the activity of writing a 'descriptive story' (see Appendix XVI).

The process of writing a descriptive story is suggested by Strauss and Corbin (1998) as one of several techniques researchers can use to "facilitate identification of the core category and the integration of concepts" (p. 148). In writing my descriptive story, I did it as an attempt to understand how the participants believed personal values and beliefs had impacted on their professional role, the types of conflicts encountered, and how they responded to such challenges. It was evident the participants at times compromised their values/beliefs, or took risks which were indicative of acting courageously. However, these responses gave priority to the autonomy of clients. Once I had summarised those points, I reflected on what the outcomes/consequences were for the nurses and clients. At the conclusion of the story I asked myself "How do nurses manage clinical situations that are contrary to their personal values/beliefs?" My answer - "They do it by giving priority to client autonomy (or what the law says when that has to over-ride)" was, for me, a crucial insight to the process the nurses used. Writing the descriptive story was a technique I found to be extremely beneficial. It was following this activity, and subsequently drawing a first draft of a diagram to represent it (see Appendix XVII), that I was confident I had found the core category.

Because the core category was not one of the 20 that existed at the conclusion of open coding, it actually caught me somewhat unaware when it clearly emerged. Its critical place within the emerging theory became obvious when I immersed myself in the data during axial coding, looking for links and patterns. In fact, once I had identified it as the core category, it was so clearly central to the study and so well grounded in the data, I found it difficult to believe it hadn't been clear to me earlier. My limited experience with constant comparative analysis could in part explain my failure to have the core category as one of the categories identified after first level analysis. That it was during axial coding its place as central to the process used by participants in the study became clear, gave me confidence it came from the data rather than any other source.

I was then able to logically link other categories to the core category. Clear patterns of relationships between the categories became evident, allowing the process of generating a substantive theory. Data analysis by using selective coding where the

categories were integrated and refined to form a theory was used (Strauss & Corbin, 1998). The use of diagrams, along with writing memos, was particularly beneficial during this phase of the study (Morse, 2006; Strauss & Corbin, 1998). This allowed me to carefully consider how each category related to the core category. The outcome of the process was a theory that explained the psychosocial process the participants used when they faced ethical issues that challenged their personal values/beliefs.

Ethical issues and considerations

The protection of the welfare and rights of human participants is crucial in all research studies, whether a quantitative or qualitative approach is utilised (National Health and Medical Research Council, 1999). Approval by relevant institutional research ethics committees to ensure appropriate consideration has been given to participants, and informed consent has been gained, is important to ensure such protection. There are also unique characteristics in qualitative research approaches that require careful consideration. The National Health and Medical Research Council (1995) requires that in such studies particular attention is given to the following issues to protect participants from harm: "inequality between the researcher and the participant(s)" (p. 25); "unanticipated consequences" (p. 25); "confidentiality" (p. 26); "reporting results" (p. 26). Each of the above principles was accepted as relevant to this study and the following strategies implemented.

Ethics approval

Ethics approval for the study was sought from, and granted by, the University of Newcastle Human Research Ethics Committee and the three regional/institutional research ethics committees that oversaw research of humans in the geographical areas where I proposed to advertise the study to recruit participants. Approval was also applied for, and granted, for the modification made to the study protocols when the eligibility criteria were widened to include any registered nurses rather than only newly registered nurses.

It is noted a small number of the study participants became aware of the study through my advertising at the approved sites, but at the time of their interviews they were working in other health care regions. Further, some participants shared

information, from their nursing experiences, which happened several years earlier and was not necessarily related to their current place of employment.

Informed Consent

To ensure informed consent, a letter of introduction (see Appendix I) was made available to potential participants, giving a brief outline of the study. A more detailed information letter (see Appendix II & Appendix III) was then given to registered nurses who met the inclusion criteria and who expressed an interest in being involved in the study. Prior to each interview, I reiterated the details of the study, as outlined on the information letter, to ensure that participants understood the intention of the study and their rights as research participants. The interviewee was then asked to sign a consent form (see Appendix V & Appendix VI), identifying their willingness to be involved, on a voluntary basis.

Equity between researcher and participants

None of the participants in the study were postgraduate students or employees over whom I had power or influence, and no conflict of interest or similar ethical risks arose during the study.

Non-judgemental environment

I conducted the interviews in a way which sensitively considered the rights and unique beliefs of each participant. It was possible, when discussing issues of belief and decision-making, participants would express views contrary to my own. I was conscious of this possibility and made sure I allowed the participants to express their opinions and beliefs but did not express mine back to them. All attempts were made to conduct the interviews without expressing judgement or bias.

Confidentiality

Confidentiality of the information shared in both the interviews and the responses to the vignettes was maintained by storing the audio-tapes, written responses to the vignettes, and transcripts in a locked filing cabinet. Only the researcher had access to the filing cabinet. Any data related to the project kept on computer disk were de-identified and password protected, including all backups. When a transcript was returned to a participant to review it was returned by mail in an

envelope clearly marked 'confidential', and to an address specified by the participant. A couple of the participants specifically requested their transcript be returned as an attached document by email and such requests were complied with.

While the study was being conducted I suffered the misfortune of having my laptop computer stolen from a locked room. This incident confirmed the value of having transcripts de-identified and in electronic files that were password protected. It was also a stark reminder of the importance of keeping backup copies of files which, fortunately, I had done.

Anonymity

Anonymity of participants has been maintained by the use of pseudonyms. The document linking the pseudonyms to the actual participants has been kept separate from the transcripts, and only the researcher is aware which pseudonym matches which participant, to further enhance anonymity. When data were shared with the research supervisors, only the pseudonyms were used. Recruiting participants from three different geographical and area health regions also aided in ensuring anonymity of the participants as well as the locations of any incidents they described.

Rights of third parties

The rights of third parties mentioned during research interviews were also respected, particularly given they were unable to present their own perspective and could not respond to any statements about themselves which might have been made by the participants of the study. Such third parties included health care organisations, patients, patients' significant others, and other health professionals. For this reason, at the commencement of each interview participants were asked that in reference to any third parties they: (1) not use any actual names of persons or institutions; (2) not identify the time or place of the event; and (3) not reveal any other identifying details (such as the social prominence of a patient). If names were inadvertently used a pseudonym was applied at the time of transcribing.

Storage and disposal of data

On completion of the study, I will erase the audio-tapes. De-identified transcripts saved on a computer disk, any notes taken during interviews, and the written responses will be stored in a secure place in the Faculty of Health at the University of Newcastle for the mandated five-year period (National Health and Medical Research Council, 1995). At the conclusion of this five-year period they will be destroyed by erasure or shredding, as applicable.

Legal Issues

When dealing with ethical issues there are often legal aspects of the situation which are pertinent. Given the close link between ethical and legal issues it is possible that participants, when sharing information about experiences with an ethical dimension, may also disclose information about legal matters. In such situations it is conceivable a participant may disclose information that implicates them legally. Although I was prepared to deal with such issues the need to do so did not arise.

Scientific Rigour

Procedures used in quantitative studies to test reliability and validity of data collecting instruments, and therefore help determine scientific rigour, are inappropriate for qualitative studies (Schneider et al., 2003). Rice and Ezzy (1999) propose various aspects or techniques which can be considered by the qualitative researcher for ensuring rigour. Theoretical rigour relates to the appropriateness of the methods chosen in the study in relation to the research problem. It is also linked to the soundness of the reasoning and arguments presented, and the analytical procedures utilised. Methodological or procedure rigour relates to how clearly the decisions in regard to method and analysis are documented. The maintenance of an audit trail, which clearly identifies these factors to a reader, is crucial. Interpretive rigour relates to how clearly the researcher demonstrates the process of achieving interpretations, and how acceptable the interpretations are to the study participants. The procedural explanations given previously in this chapter identify, in part, how these aspects were addressed in the current study. Additionally, the four criteria proposed by Lincoln and Guba (1985) to establish the trustworthiness of qualitative data and their analysis were adhered to, as described below.

Credibility

Credibility relates to ensuring the data are accurate and sound, and the researcher can have confidence in their truth (Lincoln & Guba, 1985). In this study, credibility has partly been ascertained by member checks, whereby participants were given the opportunity to read the transcript of their interview for accuracy (see Appendix XVIII). This process allowed each participant to request specific information be removed from the transcript, additional information be added, or certain information be clarified, if that was his or her wish.

Three participants requested modification to their transcripts. One participant identified that the word 'not' needed to be added to one statement in the transcript to make it accurate. A second participant added a sentence to the transcript where a section had been unable to be transcribed due to interfering sounds on the audio-tape. Additionally, this same individual added a few written comments to the transcript, feeling it was necessary to do so because the participant believed the answers were "a bit vague" and wished to clarify what was meant. The third participant made contact with me several months after the interview to request I remove one of the scenarios shared during the interview. At the time I was still developing the theory so was able to remove the data from the transcript and make certain it was not used as data in any part of the study.

Credibility of the interpretations of the data and the conclusions drawn has also been confirmed by requesting some of the participants to review the findings of the study and to respond to them. Six participants, who at the time of interview agreed to be contacted again, were requested to comment on the accuracy of developed theory and the study conclusions. They included participants recruited early in the study, mid-way through recruitment, and in the latter stages of data collection. These subsequent sessions were less formal than the initial ones and the discussions were not taped. They lasted 20 to 30 minutes. Each one of the six participants agreed the emerged theory appropriately explained the processes used when personal values and beliefs are challenged by ethical situations in nursing.

Dependability

Dependability relates to how stable the data are over time and in various conditions (Lincoln & Guba, 1985). The developing theory was shared and discussed with practicing nurses and nurse academics in forums at the University of Newcastle. In addition, aspects of, and issues related to, the study methodologies and the emerging theory were presented in papers at workshops, seminars and conferences (see Appendix XIX) at various times through the project. The feedback obtained from these groups, as well as some of the study participants, indicated positive support for the theory being generated.

Confirmability

Confirmability of a qualitative study is established by being able to attest the product, that is the "findings, interpretations, and recommendations … [are] supported by data and … [are] internally coherent so that the 'bottom line' may be accepted" (Lincoln & Guba, 1985, p. 318). An audit trail, which keeps a record of which data related to a particular category during analysis and how various links emerged, was maintained throughout the study to allow for such an inquiry (Stern & Covan, 2001). Internal logic was maintained during the constant comparative process of analysis by ensuring that as I read the interview transcripts I coded the same, or similar, expressions together. Additionally, the research supervisors provided critical review of data and their collection and analysis during the entire process of the study.

Transferability

Transferability relates to the extent to which findings from one study can be usefully applied to other groups or settings which are contextually similar to that of the original research (Lincoln & Guba, 1985). It is not intended that the findings of this study will be generalised to all registered nurses. However, action has been taken to ensure sufficient information is provided for readers of the study to make appropriate judgements in relation to contextual similarity (Lincoln & Guba, 1985).

Summary

This study used a grounded theory approach to generate a substantive theory to explain the psychosocial processes used when nurses encounter situations that challenge their personal values and belief systems. Ethics approval was sought and

obtained from four relevant institutional ethics committees. Data for the study were then collected from the 23 registered nurses who volunteered to participate. The two major sources of data used were verbatim transcripts of the in-depth interviews conducted, along with anonymous written responses to one of two vignettes. In keeping with the grounded theory method, data collection and analysis were conducted concurrently, and I followed the three coding procedures (open, axial, and selective) outlined by Strauss and Corbin (1998). These procedures enabled me to develop a substantive theory grounded in the study data. Lincoln and Guba's (1985) four criteria of credibility, dependability, confirmability, and transferability were applied and reported to establish scientific rigour of the study.

In Chapter Four I provide context for the study by giving a brief overview of the general environment in which nurses worked at the time data were collected for the study and identifying some of the types of ethical challenges the participants of the study reported they had encountered. I then summarise the substantive theory which emerged from the data, identifying the various categories identified and how they link and relate to the core category.

Chapter 4

Introduction to the Theory and its Context

I think that it happens all the time that your personal values are challenged, if you're aware of them. It's not something that only comes up every now and then, it's sort of an ongoing process where you're trying to input what you think is good against what the system's providing. [Austin].

It is accepted experiences and events are contextual. The nature of nurses' work places them into environments where they are required to interact with clients and colleagues from many backgrounds and with varying allegiances. The risk of situations arising where personal values or beliefs may conflict is ever present. If the working environment is also demanding, requiring decisions to be made with little time for reflection and with limited resources, the ethical challenges are multiplied. An insight into the working environments and circumstances in which nurses encounter ethical challenges provides a background for better understanding the way they respond to them.

Chapter overview

In this chapter I will provide information aimed at portraying the context from which the developed theory emerged, along with a brief introduction to the theory. A description, in general terms, of the health care environment in New South Wales, Australia, during the period of time data for the current study were collected is given. This, in part, provides an understanding of the milieu and conditions in which the study participants worked. Examples, from the data, of the types of ethically challenging problems faced by the participants are also presented to give a general overview of the types of situations to which nurses have to respond. Finally, I outline a brief overview of the substantive theory developed from the study data. This provides an overview before detailed discussion of each category in the theory is given in subsequent chapters, with the whole theory and its implications being explored in the final discussion in Chapter Nine.

The context in which ethical challenges occur

Contextual background to the study is provided through a description of the current health care system in Australia, and more specifically in New South Wales, along with the major issues impacting on the nursing profession during the time of data collection. It is acknowledged some of the situations shared by the participants happened several years ago, and in other healthcare contexts. However, this does not reduce their relevance to the study because many of our values and beliefs tend to persist over time. Additionally, many examples given were very recent. Further, when providing descriptions of how they make ethical decisions and deal with challenges to their personal values/beliefs, the participants focused on the current processes they use.

The current health care environment

Nursing in Australia has undergone major changes in the past two decades, particularly in the area of education. Prior to 1985, the majority of nurses were trained in hospital-based apprenticeship style programs. However, in 1985 all undergraduate nursing education was transferred to the higher education sector in New South Wales, a move completed Australia-wide in 1993 (Russell, 2000). Colleges of advanced education were subsequently amalgamated into the university sector in the early 1990s. Therefore, within one decade, nurse education programs progressed from being offered at certificate level in hospitals, to being offered in universities at both undergraduate and postgraduate level (Pratt, 1995). Thirteen of the participants in this study undertook their initial training in the hospital-based system with nine subsequently completing conversion or postgraduate studies in higher education institutions. Other participants completed their initial nurse education at Bachelor degree level and some of them have also subsequently completed postgraduate degrees.

During the time of data collection for this study, nurses in New South Wales worked in a variety of health care environments with just over half (51.6 per cent) working in public hospitals. A further 12 per cent worked in private hospitals, while the remainder worked in community services, aged care homes and hostels, and other public or private settings. Overall, 75 per cent worked in the public sector and 25 per

cent in the private sector. The majority of registered nurses in NSW were women, with men accounting for 8.1 per cent. The modal age range in 2002 was 45 to 49 years, with only 32.8 per cent of registered nurses aged less than 40 years (NSW Health, 2002).

Despite having to work in environments presenting many and varied challenges, there is evidence nurses in Australia are viewed favourably by the general public, particularly in regard to being honest and ethical. This is supported by findings from the Roy Morgan Poll conducted in November 2005 which reported nurses had, for the twelfth year running, been identified as the most honest and ethical out of a list of 28 professions (AAP, 2005; Pharmacy Guild of Australia, Australian Nursing Federation, & Australian Divisions of General Practice, 2005)[6]. With pharmacists and doctors consistently ranked second and third in the list there is evidence the Australian community highly values the way these professionals make their contribution to health care services.

In Australia, nurses account for about 30 per cent of the health industry workforce (National Review of Nursing Education (Australia), 2001). They therefore constitute a significant group, and in fact are the largest single group in the provision of health care services. However, during the time data were collected for this study, Australia was experiencing a shortage of nurses in most specialisations and this shortage occurred throughout many metropolitan and rural areas of New South Wales (National Review of Nursing Education (Australia), 2001). This affected the work environment for many nurses, because staff shortages meant heavy workloads and nurses often found it difficult to provide the level of care they would have preferred to give their clients. The resulting frustration this caused some of the research participants was evident by statements made during their interviews, some identifying the limited staffing levels compounded, and at times caused, ethical challenges they were facing.

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[6] The 2005 result is reported here to indicate polling through the data collection time period for this study consistently ranked nurses as highest. Subsequent poll results have continued to report nurses ranked highest (Nursing Review, 2007).

Media reports about nursing in New South Wales during the period of data collection covered a variety of issues with some receiving significant coverage and being pertinent to this discussion. In particular, problems associated with nursing shortages were identified, along with the associated issues of work conditions, pay rates for nurses, and lack of hospital beds for public patients. There was also wide coverage, over several months, of issues related to an investigation over patient deaths at two Sydney hospitals, commenced because of complaints brought forward by five nurses.

The shortage of nursing staff was highlighted with news headlines such as 'Shortage of nurses nears crisis point' (Robinson & Contractor, 2001) and 'Hospital crisis as nurses walk out the door' (Metherell & Kerr, 2002) bringing the issue to the attention of the public. A drop in the number of students actually choosing to enter nursing in 2002 added to the problem and was identified as a reason for closing more hospital beds as indicated in the headline 'Unis fail to train nurses as wards shut' (Contractor, 2002). In May 2002, a report, commissioned by the New South Wales Nurses' Association, identified that nurses were equally as concerned with work conditions as they were with pay levels and many were leaving the profession as the result of work-related stress. The headline 'Stressed nurses leaving in droves, blaming shortages' (Pollard, 2002b) highlighted the impact of this on the provision of health services.

Nurses in New South Wales were granted a six per cent pay rise in December 2002 as part of the strategy to retain them in the profession as well as to attract non-working nurses back and recruit new nurses (Pollard, 2002a). The shortage of nurses was still an issue in New South Wales in 2004 with "a lack of staff and infrastructure support, burnout, poor perception of nursing as a career, and a reduced student pool as government decrease funding for nursing positions" identified as major causes (Date, 2004, p. 4). Recruitment of students into nursing was further highlighted as an important issue when the University of Sydney announced, in June 2004, it would phase out its undergraduate nursing program from 2005 (Robotham, O'Malley, & Pollard, 2004). Because of the perceived lack of value it placed on nursing and the

already existing problem of a shortage of nurses, the move attracted much criticism, particularly within the nursing profession (Lumby, 2004a; O'Malley, 2004).

Problems associated with patient care and management at Campbelltown and Camden Hospitals, in the Macarthur Health area of Sydney, between 1999 and 2003 were brought to public attention when the matter was discussed in the New South Wales State parliament. Following reports made directly to the then State Minister for Health, Craig Knowles, by five nurses whom the media dubbed 'whistle blowers', the Health Care Complaints Commission (HCCC) carried out a 10-month investigation. The "investigation found that at least 17 patients who died … had received 'unsafe, inadequate, or questionable care'" (Gibbs, 2003, p. 8). Several issues of concern emerged from the investigation and its aftermath, with particular focus on declining resources leading to medical and nursing staff shortages which in turn placed excessive pressure on the hospital staff (Pollard, 2004a). When the final report was released, Morris Iemma, the then State Minister for Health, "was forced to admit the Government had failed the sick, and that the State's health watchdog had botched its inquiry" (Pollard, 2004b, p. 18). As a result the HCCC's commissioner and the general manager of Macarthur Health were dismissed from their positions. Additionally, a special commission of inquiry was established to further investigate the two hospitals, and nine doctors were referred to the Medical Board (Pollard, 2004b).

The issue received further media coverage when the Independent Commission Against Corruption (ICAC) investigated whether Craig Knowles "bullied and intimidated nurses who were attempting to expose patient mistreatment at Camden and Campbelltown hospitals" (Pollard, 2004c, p. 2). The ICAC (2005a) report relating to this investigation was released in April 2005 and found that the conduct of Knowles towards the nurses was not threatening, intimidating or improper. A second report, released in September 2005, reported on extensive investigations of other allegations made by the five nurses about misconduct by various parties working in the South Western Sydney Area Health Service. The commission reported that the allegations were not substantiated and they had not found any corrupt conduct (ICAC, 2005b).

The on-going media coverage of this story, over several months, brought major concerns about the public health system in New South Wales to the attention of both nurses and the community. The pressures under which some nurses work in New South Wales was also highlighted along with the challenges that may exist for nurses if they whistleblow. Although none of the participants of this current study were directly involved in the situation, the possible effect of such media reports on the morale of nurses in New South Wales during the data collection period needs to be acknowledged.

The climate in which nurses worked at the time of data collection, and reasons for an on-going problem with both retention and recruitment of nurses is perhaps best described by Lumby (2004b), who stated:

> International research shows that nurses are leaving our system for a multitude of reasons and that pay is not their first concern. Nurses in our hospitals now care for a radically different patient population. Those in their care are sicker, older and often attached to machines which require as much attention as the patient. On one hand they are required to manage highly sophisticated technology and perform specialist tasks, and on the other they are still treated like inferiors. (p. 15)

It is within this type of environment many of the participants for this study worked.

Examples of ethically challenging situations

The broader socio-political context of nursing practice is reflected in the more immediate work environment of the study participants. Under such conditions, it is not surprising that they reported ethical concerns to be ubiquitous:

> *I face situations that are ethical dilemmas and confront who I am as a person professionally and personally, you know, many times each day. [Katelyn].*

> *I think it's a fairly critical part of nursing. There's nurses that do have ethical issues every day that they go to work, that they face. [Tim].*

Before describing the psychosocial processes nurses use when their personal values and beliefs are challenged in the course of their work, I will outline a range of

the types of ethical issues they encounter. These are taken from the numerous examples reported by the participants. This augments the description of the general health care context and provides real life examples of personal challenges to further illustrate the context. Some of these examples will be referred to again, and discussed in more detail in Chapters Five to Eight, when describing the categories in the substantive theory.

Risk to client autonomy

Some examples illustrated situations where nurses believed client autonomy was at risk. Because they valued autonomy so highly, these situations caused the nurses to feel personally challenged.

> *One concerned a man who had advanced cancer and he had not long to live, maybe a week or two weeks. And he was charted regular Midazolam fourth hourly and morphine for pain relief. And he was refusing the Midazolam, saying that it just, he felt very zonked out. And I would not administer that Midazolam if he had refused it. But the staff who were in charge were virtually accusing me of lying because I hadn't given him this Midazolam, as it was his request. And they were more or less insisting that I gave it to him on a regular basis whereas I felt he really didn't need that Midazolam, he needed more personal attention from the nursing staff. [Michelle].*

> *So the oncologist wanted us to encourage him to go back for further treatment. And already my ethics were kicking in, that if this man who's 70 something has got cancer and doesn't want treatment, who am I to say he has to have it? [Mikaylah].*

When a nurse cannot adhere to a client's wishes because legal constraints become a barrier, it can be particularly distressing for the nurse. This is illustrated in the next situation.

> *But for me the dilemma was poor man, I was his friend, I let him down. I know I had no choice but to ring an ambulance, but I felt bad about that…. The more I knew him the more difficult it was. And to see him go away in an ambulance, and I thought 'oh god, that's not what he wanted.' And then to see him in the [emergency department] and they're trying to put tubes down him. It was quite awful. [Emeline].*

Alternatively, because nurses support the right of clients, or their significant others where appropriate, to make self-determining choices, dilemmas can result for nurses when choices are made which contravene their own values and beliefs.

We had a child who was born with severe … hydrocephalus. And when they did the ultrasound there wasn't very much brain matter and so a decision was made to withhold feeds. Now withholding feed is, that doesn't go in the highly technical basket. We do that [feeding] all the time. And so that was a dilemma for me and I wasn't happy about it. [Jade].

Risk to the dignity of clients

Respect for the dignity of clients and their rights as human beings can, unfortunately, sometimes be neglected or jeopardised. When nurses observe such incidents occur it can be ethically troubling for them.

It was just a culmination of our complete distress that what we saw as just an abandonment of this lady's rights and just the duty of care. So just an awful situation to be in because…. She really wasn't valued, she wasn't heard as a human being. I mean we believe one has the right to be heard and we didn't feel she'd been heard. [Katelyn].

Admitted a patient 87 years old, female, dehydrated, congestive heart failure, interesting combination, and the doctor's order was to start IV fluids. I assessed my patient, called the doctor back and said she doesn't have long, there's nothing we can do, she has no veins. He says 'the family wants everything done. To cover myself and liability I want those IV fluids going before she dies.' He didn't dispute the fact the she was not long for this world. There was at one time 5 nurses sticking her. I had to walk out. It almost became very objectified and this was an opportunity for everyone to practice their skills at cannulating. And I was horrified. I had nightmares. It still upsets me. [Chloe].

I've actually had a patient with a very rare condition that they just kept bringing in all these doctors to. And she was only very young and was facing death, and she'd had a young child. And I said to her 'you realise you have a right to tell them no, I don't want anyone else in here. Do this test and leave me alone.' And she said 'can I?' And I said 'yes you can.' Well she did the next day. So I don't know if that was a good thing for me. I felt ethically justified to let her know that no you don't have to be a guinea pig for every single doctor to come in and have a look at because it's something rare. Maybe I've crippled them [the doctors] in their learning experience but for her as an individual and a person she'd had enough. [Carlee].

Quality of life versus prolonging life

Nurses can feel personally challenged when they believe treatment is futile and that the prolongation of a life is not being appropriately balanced against the quality of life.

And we had a really good rapport. I was with him when the surgeon walked in and goes "oh I've scheduled a surgery for you tomorrow, it's really good, sign the consent when the anaestheologist is here tomorrow, it's going to do…. And when the surgeon left … I sat down with him and said "Listen. You have the right to refuse this surgery. You must weigh the quality of your life and your personal goals. If you've done everything you want to do and you want to let go you don't have to have this surgery. If you have more to do then that surgery may offer you more time to do it in. But just know you've got the choice. And it's moral and it's OK". And when I returned three days later he was dead. That hit me really hard. I was at peace but it hit hard because of the power we have when we empower our patients. It was his decision. I did not sway him but I freed him to make his decision. And it was a huge impact on me. [Chloe].

Competence of nursing colleagues

There are times when nurses find they are working with colleagues who are failing to carry their work load, or who are contravening institutional protocol. This can be personally challenging to nurses who value a strong work ethic, especially if they are in a more junior position.

I'm working with this lady … she's smoking on a regular basis … she's just sleeping more than two hours … she's sleeping from 1 o'clock in the morning and I try to wake her up … so lately, still 8 o'clock in the morning and we haven't finished the reports … and I said to the NUM, I said she is one of your permanent nurses here and you have no idea how difficult this is for me to bring up this issue. [Yasmin].

Allocation of resources

The way in which resources are allocated can also be a cause of ethical challenge for nurses, particularly if they believe clients are being disadvantaged by the situation.

You know they, management, will cut our services. They'll cut our services and we know who it's going to impact on. It's going to impact on our patients. They've cut the transport. They cut, you can't have that many pathology tests. You can't have this and you can't have that…. But I guess that's in response to a change in budget and having to cost cut all around the hospital. These sort of things get snipped and they think they can do without them. And maybe they can but patients are the ones that lose. [Angela].

They [nurses] just want time to do the job that they've been employed to do. They need the time to talk to their residents. They need time to look after them. So I don't think paying them more money is going to solve the problem. What you need to do is give time, more time to do the job. And I think that that's one of the major ethical dilemmas that are sort of happening at the moment…. It's

not being able to deliver care to people that they saw that they deserved. [Emma].

As these excerpts from the participants' interviews illustrate nurses regularly encounter situations which have ethical components. They may at times confront the so called big and complex issues, which are often the focus of ethical discourse, such as abortion and euthanasia. But much more frequently they encounter what may be considered more mundane but personally challenging situations. An example of this is provided in the next interview excerpt where a nurse identifies that even the setting of work priorities has an ethical component:

> *I haven't given that medication on time and I know I haven't. And the relatives have just confronted me about it, and this person has walked past and said 'Well why haven't you done it?' Well I've just spent three hours in with her and I had to go and see my other six or seven patients who need to be seen and that's why the medication hasn't been given at exactly quarter past ten.... Ethically you feel well, yes, I would like to have given that medication on time but I had some responsibility that required my assistance here and you can't be everywhere. [Amanda].*

A recent study by Johnstone, Da Costa and Turale (2004) surveyed nurses working in Victoria, Australia, to explore the ethical issues which caused them the most concern. Similar types of ethical dilemmas to those outlined by the current study participants were identified in the Victorian study. Issues the respondents reported as causing them the greatest personal disturbance were:

> staffing patterns that limited patient access to nursing care; prolonging the dying process with inappropriate measures; working with an unethical/incompetent/impaired colleague; caring for patients/families who are uninformed/misinformed; providing care with possible health risk; and, not considering a patient's quality of life. (Johnstone et al., 2004, p. 25)

Additionally, they indicated they were primarily concerned about ensuring the welfare, rights, and dignity of clients were protected, and that decisions made by clients in relation to treatment were informed and respected. Findings in the current study add to those by Johnstone et al. (2004) and provide further evidence that nurses frequently encounter a diverse range of ethical situations which cause them to be personally challenged.

Given the types of environments in which nurses currently work it is not unexpected their personal values and beliefs will, at times, be challenged. The initial literature review and a description of the contextual background for this current study indicate that nurses interact with many different people in their professional capacity, and regularly carry out a large range of activities with ethical components to them. Additionally, some nurses work in settings where they have limited involvement in the decision-making process and therefore have to carry out decisions made by others. Participants in this current study also provided many personal examples of situations, during the course of their work, where there was a need to resolve conflicting values and beliefs. An understanding of the way nurses reason through and deal with these situations is crucial to appropriate nursing practice. It is also important for the nursing profession to be aware of the processes used by nurses when ethically challenged if appropriate support is to be provided. The substantive theory generated from this study adds to nursing's body of knowledge by identifying and describing the processes used to deal with challenges to personal values and beliefs which occur in the work environment.

The substantive theory

A brief overview of the substantive theory is now outlined. This serves as an initial introduction to the psychosocial processes used by nurses as they respond to and deal with challenges to their personal values and beliefs. There is benefit in viewing the theory as a whole before detailed descriptions and explanations of each category are revealed later, as it assists the reader to understand how each of the sub-processes and the core category link together.

When nurses encounter situations in their professional environment that cause them to feel ethically challenged and to question if something is right, or not, they predominantly think and reason for themselves. The process is one that is primarily conceptual rather than communicative or interactive. However, uppermost in their minds as they reason and respond is protecting client autonomy.

Protecting client autonomy emerged as the basic psychosocial process used and is therefore the core category in the theory. It subsumes four key processes through which nurses move while they give consideration to client autonomy and its protection. The four subcategories are: (1) **being self-aware**; (2) **determining duties to other/s versus self**; (3) **engaging self as protector**; and (4) **restoring self from tension or anguish**.

Figure 4.1 below illustrates the substantive theory, outlining each of the categories involved in the process of protecting client autonomy, and showing how they link.
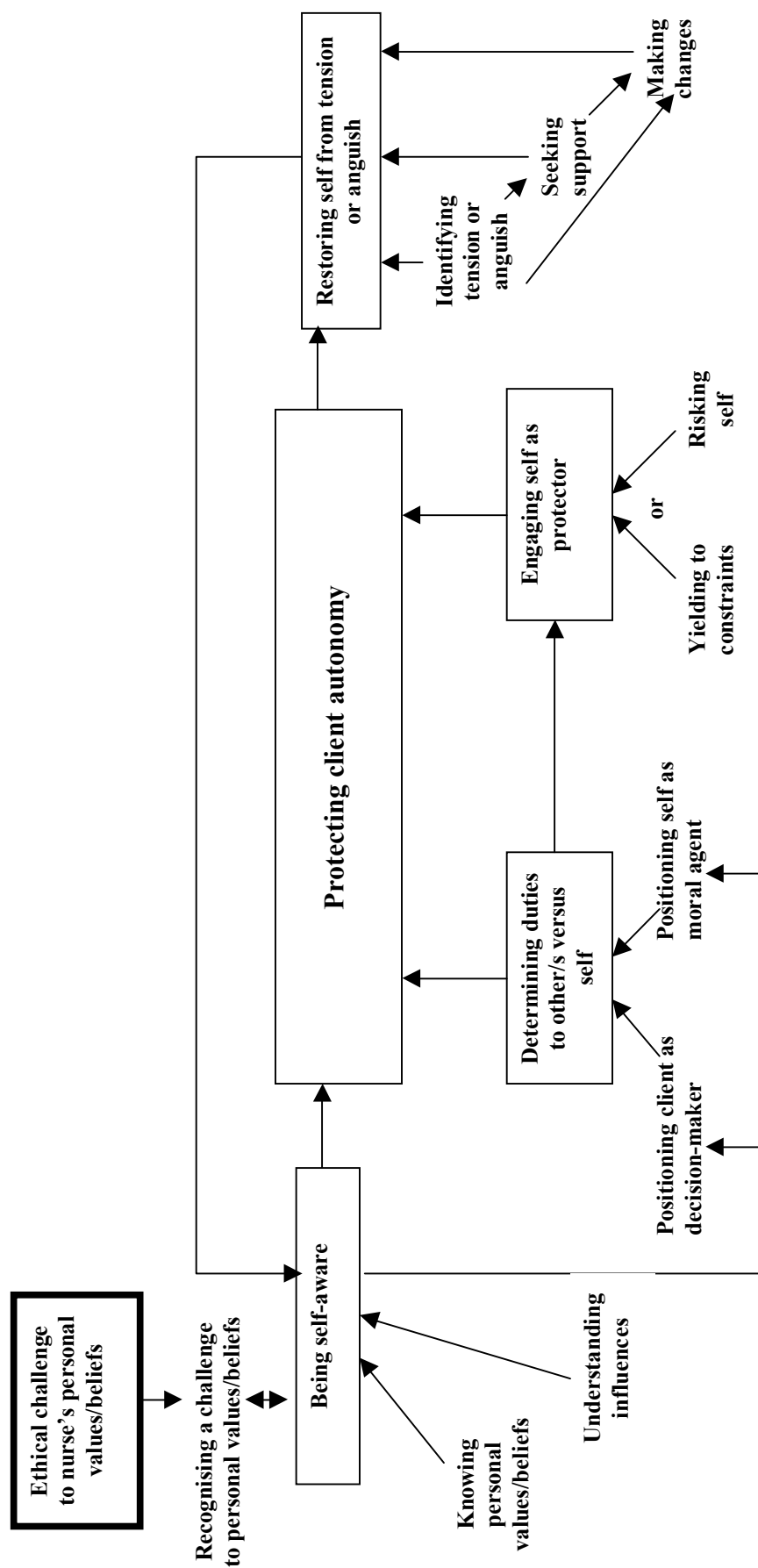
Figure 4.1: The substantive theory

Core problem: Ethical challenge to nurse's personal values/beliefs

Basic Psychosocial Process (Core Category): Protecting client autonomy

Protecting client autonomy

The basic psychosocial process (core category) nurses use when responding to challenges to their personal values and belief systems is 'protecting client autonomy'. In this theory the term is used to refer to a recognition nurses have, and act on, to ensure they protect clients' rights to make decisions for themselves, based on their own values, beliefs and life circumstances, in relation to their care. Client autonomy emerged as the paramount value that guides nurses as they reason through and respond to ethically challenging clinical situations.

Being self-aware

Protecting client autonomy requires awareness of self as a moral agent. In the context of this theory, being self-aware is a process of recognising one is being ethically challenged along with identifying what one's personal values and beliefs are and how they would be prioritised when conflicts occur, especially if multiple values/beliefs are being challenged. Additionally, being self-aware is a state of understanding what has influenced the development of one's personal values and beliefs as well as how and why they may be modified over time. There are therefore three phases in the category of being self-aware: (1) **recognising a challenge to personal values/beliefs**, (2) **knowing personal values/beliefs** and (3) **understanding influences**.

Determining duties to other/s versus self

Determining duties to other/s versus self is a process nurses go through whereby they determine what their duties are to another individual, or others, involved in the situation, versus their duties to themselves. Their responsibilities to clients and the protection of their autonomy remain a major focus throughout this process. However, they also consider what their moral duties are to themselves and whether or not they are prepared to compromise any of their own personal beliefs and values. There are two major phases in the category and they tend to occur concurrently as nurses cognitively reason through the issues associated with having their personal values/beliefs challenged. The two phases are: (1) **positioning client as decision-maker** and (2) **positioning self as moral agent**.

Engaging self as protector

Engaging self as protector, in the context of this theory, is a process of actively becoming involved in the role of protecting client autonomy. Nurses take this role seriously with their focus, as moral agents, on ensuring that clients' needs and wishes are protected. When nurses engage themselves as protectors they choose one or the other of two possibilities. The one chosen depends on the particular situation and the decisions made previously when determining duties to other/s versus self. The two ways of engaging self as protector are: (1) **yielding to constraints** and (2) **risking self**.

Restoring self from tension or anguish

Engaging self as protector of client autonomy takes energy and can cause emotional strain, even if the outcome is acceptable to the nurse. Restoring self from tension or anguish is a process where nurses become aware they are experiencing consequences to self as an outcome of being personally challenged and so seek ways to resolve such reactions. As nurses work through the states of tension or anguish they will often find themselves reflecting further on their personal values/beliefs and may, at times, make personal or professional changes. Therefore the activities that occur through this process feed back into the category of being self-aware as nurses gain more knowledge and understanding of their personal values/beliefs and the influences on them. There are three phases that exist in this category: (1) **identifying tension or anguish**; (2) **seeking support**; and (3) **making changes**.

Summary

The Australian community has a favourable view of nurses, perceiving them to be the most honest and ethical of professional workers. However, many of the media reports about nurses and the health care system in New South Wales during the period of time data for the study were being collected focused on issues that were problematic for the nursing profession. In particular, the recruitment and retention of nurses and the associated nursing shortages received attention. Additionally, whistleblowing by five nurses concerned about the quality and competence of health care services provided in one health area in Sydney received high media coverage.

Such media reports highlight some of the difficulties encountered by nurses in a work environment that regularly requires them to deal with personal ethical conflicts.

The ethical concerns reported by the study participants provide evidence that nurses work in environments where they regularly encounter ethically problematic situations, often related to the rights, welfare, and dignity of their clients. In particular, the participants reported several ethically challenging incidents related to clients being afforded the right to self-determination. This sets a background in which the substantive theory that emerged from the study data is embedded. It is a theory in which **protecting client autonomy** has emerged as the basic psychosocial process (core category) nurses use when dealing with ethically challenging clinical situations. This subsumes the key processes (subcategories) of (1) **being self-aware**, (2) **determining duties to other/s versus self**, (3) **engaging self as protector**, and (4**) restoring self from tension or anguish** which link to each other and to the core category.

In Chapters Five to Eight I describe, in detail, each of the four categories listed above, and in Chapter Nine I describe the core category, followed by a discussion of the theory and its implications.

Chapter 5

Being Self-aware in Ethically Challenging Situations

I think the first issue on ethical questions and being challenged is knowing where you are personally. If I don't know where I'm at personally how on earth am I going to handle it when I'm challenged about something that I don't have the faintest idea about, that I don't have much of a grasp on. So I've got to know where I'm at. [Cameron].

Effective interpersonal relationships, whether personal or professional, require each individual to have some awareness of who they are, what they value and believe, and how what they bring into any relationship affects others. In clinical nursing practice, nurses often find themselves in situations that directly challenge their values and belief systems. Others involved in these situations, whether clients or colleagues, draw nurses into situations where various duties or loyalties might prevail. The initial step when responding to such encounters in a reasoned and considered way is to reflect on one's own values and beliefs and what it is that calls them into question or conflict.

Chapter overview

In this chapter, I will discuss the first of the four categories – **being-self aware** – that make up the basic psychosocial process of protecting client autonomy. Included in this discussion will be an outline of the way in which: (1) **nurses recognise they are being ethically challenged**; (2) **the need to know what their values/beliefs are**; and (3) **the importance of understanding factors that influence their values and beliefs**. I will, in turn, describe each of the three phases nurses use to remain self-aware as they attempt to resolve ethically challenging situations.

Category 1: Being self-aware

Protecting client autonomy requires awareness of self as a moral agent with choices and the ability to act on them. Being self-aware is especially evident when a nurse's personal values or beliefs are at odds with actions he or she is expected to take. In the context of this theory, being self-aware is a process of recognising one's values/beliefs are being challenged along with identifying which personal values and

beliefs are involved and how, when multiple values are in conflict, they would be weighted. Additionally, being self-aware is a state of understanding what has influenced the development of one's personal values and beliefs along with how and why they may be modified over time.

Many nurses work in environments which bring them into situations that would be considered, by the general public, to be out of the ordinary. The nature of nursing work is such that it requires nurses to carry out functions which would be considered most irregular in conventional social settings. Such environments bring with them a plethora of ethical challenges requiring nurses to be self-aware if they are going to cope with the situations they encounter.

> *My work is really intensely not normal. I mean this is acutely ill people we're focussing on. And everyone I see is dying, everyone that I see is ill. And everyone that I see has some sort of functional problem or something that I need to fix so I'm problem solving all the time. [Katelyn].*

When personally challenged by situations, nurses who are self-aware are able to recognise what is happening within themselves as well as around them. This is crucial to the process of dealing with challenges to their personal values/beliefs because failure to clearly identify the cause of conflict and the pertinent values/beliefs being challenged, limits nurses in their ability to respond appropriately. Until nurses are clear about who they are, and what they think and believe, there is a risk they will be preoccupied with dealing with their own feelings and concerns, rather than being focused on clients and their needs.

> *It was something that some people hadn't really thoroughly examined before ... they found it really hard. Whereas I'd contemplated how I felt about the whole situation, and it didn't really go against my ethics, so to speak, in this situation. [Holly].*

Being self-aware involves nurses understanding themselves, particularly in relation to how they reason and make decisions when ethically challenged. How they actually prioritise values, especially when multiple values are being challenged, and justify their decisions is an important part of this process.

> *To survive in a role such as this I probably need to have defined myself as a person, 'who am I?', 'what do I think?', 'what do I believe?' [Katelyn].*

To become self-aware nurses need to reflect on the questions in the study participant's statement above, and answer them with honesty and self-insight. This is particularly important when they find themselves feeling uncomfortable but are unsure as to the cause of the discomfort.

> *And you feel uncomfortable about that, and I didn't understand why.... I didn't understand why I didn't like that, I just knew that I didn't like it.... I can now say 'didn't like that because'. And so I can now put value on that and put words and understanding as to why I didn't like that.... So it's been for me a sort of maturing in my understanding of who I am. [Katelyn].*

It is not until they can clearly determine what it is in a particular situation which causes them to feel a sense of unease, that nurses can actively, and more importantly, effectively, deal with it in an appropriate way.

Nurses need to actively work at being self-aware. It is not a passive activity and to expect self-awareness will automatically come with time and experience is naïve. Unfortunately lack of self-awareness can be observed in nurses at various levels and it is a limitation to them.

> *I would love to see nurses a little more self-aware ... in order to perform well and care for people as a professional I think we need to be self-aware and I'm alarmed that I don't see a lot of self-awareness even among more senior nurses. [Katelyn].*

Research supports the benefit of helping undergraduate nursing students develop self-awareness (Lemonidou, Papathanassoglou, Giannakopoulou, Patiraki, & Papadatou, 2004; Thorpe & Loo, 2003). However, the data in this current study indicate the process of becoming self-aware is not confined to nursing students. Given the evolving nature of moral development, and the variety of ethical challenges nurses may encounter, registered nurses need to ensure there is an ongoing process of self-awareness which continues after graduation from their initial program of nurse education. Nurses continue to learn and develop through clinical practice and nursing experiences.

> *I did form different views as I went along ... because of the experiences I've had, certainly to do with life and death and the value of living and age and sickness. I have developed a lot of different thoughts which are probably very different from when I started nursing. [Amanda].*

Remaining self-aware must take into account any modifications that occur as a result of these experiences. Being self-aware is a state which develops over time and requires that individuals actively self-reflect on an ongoing basis to gain a better understanding of themselves.

Various strategies are used by nurses to become self-aware. Data in the current study indicate these include some of the strategies used to actually deal with the effect of having one's personal values and beliefs challenged, such as reflecting on encounters which cause conflict. Talking about ethical issues with other people, both within the work environment and outside of it can also assist nurses with self-awareness. These will be discussed further in Chapter Eight of this thesis, recognising that the awareness of self which develops as a result of these strategies feeds back to this category of 'being self-aware'.

Being self-aware makes it more likely that a nurse will recognise his or her personal values and beliefs are being challenged. Self-awareness results in nurses recognising the responses which initially alert them to the existence of a situation that is challenging them personally, so these responses signal the existence of an ethical problem. To be self-aware they need to be knowledgeable about the values and beliefs they hold in order to determine which ones are being affected by an ethically challenging situation. Further, they need to know what has influenced them to hold these particular values and beliefs and to recognise there can be on-going influences which may modify them.

Although focussing on physicians, Novack et al. (1997) promote the benefit to client care of being self-aware, especially in regards to "values, attitudes, expectations, and biases" (p. 507). Failure to be sufficiently self-aware can limit, and at times adversely affect, the ability of health care professionals to effectively communicate with clients. This can compound ethically challenging situations. When nurses fail to examine their own beliefs and their biases, they also risk giving inadequate recognition to the beliefs and views of their clients, limiting their ability to appropriately consider the individualised needs of clients (Pask, 1997).

It is evident from the data that there are two levels of self-awareness. The first is an overall awareness of self that enables one to answer questions such as: 'Who am I?'; 'What do I believe?'

> *So I think that helps self-development and I think the important thing is that you need to find out about you. And once you find out about you and where you're heading, then you move on to the next stage. [Emma].*

It involves an individual knowing which values and beliefs they hold and why, and which are considered to be core. Additionally, understanding which values or beliefs he or she would be prepared to compromise is involved in this level.

The second level is a situational awareness which enables a person to identify what it is about a particular situation that results in the actual response, such as concern, worry, anger, or distress, being experienced.

> *You're in a situation where you are there to save lives but it may not feel the right thing.... I see tons and tons of blood going into a motor vehicle accident victim who is not going to survive and yet you use it because it's the right thing to do. So I have, you know there's an ethical struggle there and it's going on and I'm bringing myself to it. And I'm saying 'is this really the right thing we're doing?' [Amanda].*

> *I've been raised with that certain things are a mortal sin and should never occur ... therefore very often I have to take, if I'm starting to feel uncomfortable, I have to look at that and I think that's where it's coming from. [Lauren].*

In this level of awareness nurses identify the specific issues, within a situation, that cause them to feel ethically challenged and why it is impacting on them personally. Questions such as 'Which values are being challenged by this situation?' and 'What options are open to me here?' are raised. Because of the need to consider personal values and beliefs and whether there is willingness to forfeit any, self-awareness at the first level is required in order to proceed through the second level.

There are three phases which need to occur for a nurse to be self-aware. These involve (1) knowing how to recognise there is a challenge to personal values/beliefs, (2) knowing what one's personal values and beliefs are, and (3) understanding the influences that can impact on one's personal values and beliefs. Each of these will be discussed in detail.

The coloured sections in Figure 5.1 below illustrate where the category of 'Being self-aware' fits into the substantive theory and how the phases within the category relate. Each one is discussed in turn.
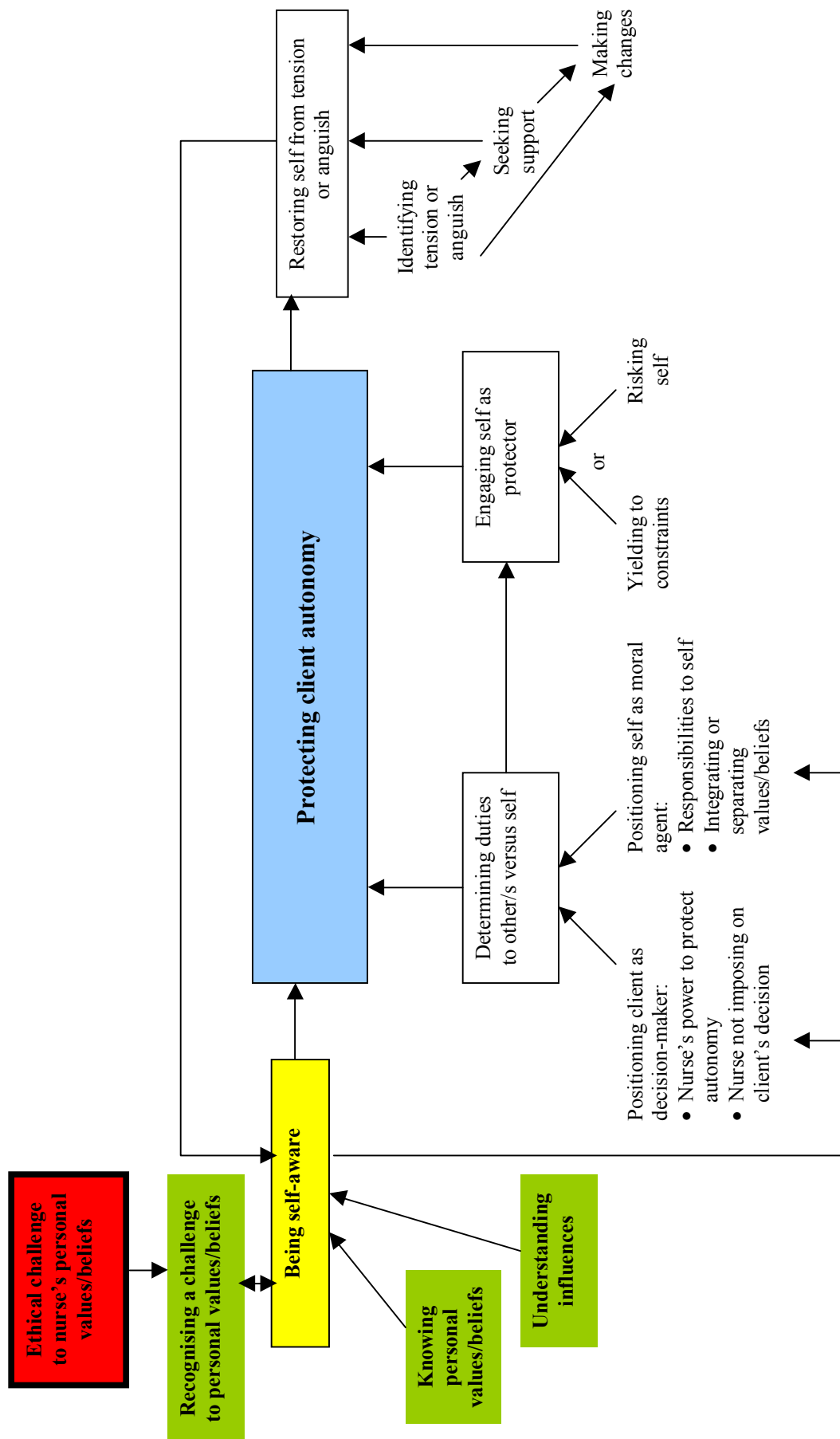
Figure 5.1: Category 1 - 'Being self-aware' and its place in the theory

Recognising a challenge to personal values/beliefs

To initiate the process of dealing with one's personal values and beliefs being challenged it is first essential a nurse recognise it is actually occurring. Data in this study indicate such recognition is often described by nurses as an emotional reaction or a physical response. Discomfort experienced as an emotional or physical feeling, rather than a reasoned cognitive process, alerts them to the existence of an ethical problem.

I might know instinctively how I feel about it because I get that urkey feeling inside 'this is not right' or 'this doesn't sit comfortably with me'. [Meagan].

Nurses sometimes describe being aware of an ethical challenge as an embodied sensation.

I think the process is I have this initial gut feeling anyway that I'm being, you know my ethics are being challenged ... it's a physical stress anxiety response to something which goes in hand-in-hand with 'this isn't right'. [Mikaylah].

It's really just to get rid of the sort of knot in your stomach that says 'oh I don't like that sort of thing'. [Kylie].

These embodied reactions can be simply feelings of discomfort.

I feel a little bit uneasy for him you know. And I guess that just makes me feel a little bit anxious and makes me want to work a little bit harder with him going through the issues. [Rachel].

Conversely, depending on the nature of the challenge, the reactions may at times be quite debilitating.

When I first found out I felt physically sick. It weighed me down that much I felt physically ill to the guts. [Holly].

When things are incredibly conflictual I do get headaches and migraines. [Krystal].

Nurses may also experience multiple emotional responses which warn them of the need to further question and investigate what is going on.

Why did I want to cry in that situation?... Why was I, you know, angry? My heart was pounding, I was sweating profusely in the consult. Why was that? [Katelyn].

So the recognition of the existence of these embodied responses alerts nurses of the need to reflect on what is happening to cause such a reaction.

These embodied sensations indicate that reacting to an ethical challenge is more than simply a cognitive reasoning process. Understanding this, along with how it can be used to inform nurses about what is happening to them, is an important part of dealing with ethically challenging encounters. There is evidence in the data that nurses do not just 'think' ethics, they also 'live' it as indicated by these embodied responses. That nurses will at times identify the existence of an ethical challenge by experiencing an emotional or physical response is an important finding. Much of the nursing literature about ethical reasoning by nurses relates to the cognitive processes they use once the actual existence of an ethical situation or problem is identified. (Coverston & Rogers, 2000; Dierckx de Casterle, Grypdonck, Vuylsteke-Wauters et al., 1997; Gibson, 1993; Oberle, 1995; Parker, 1990; Raines, 2000; Riesch et al., 2000; Smith, 1996; Uden et al., 1992; Ustal, 1990). However, little attention has been given to the issue of how nurses actually recognise the existence of an ethical conflict in the first place and the role emotional and physical responses play in this. Nurses need to give attention to their emotional and physical responses to situations, and not simply dismiss them. Failure to recognise them as a signal of the existence of potential ethical problems limits the ability to both identify ethical concerns and to then deal with the consequences.

Although identification of an ethically challenging situation is often through emotional or physical response, this does not negate concurrent use, at least by some nurses, of a cognitive process to determine or confirm its existence.

> *I'm very much a head person so have very clear logical constructs that frame my perceptions of what I think is right and wrong … they're like my governing principles so that everything gets filtered through that. [Krystle].*

While reflecting on the embodied response being experienced, thought may also be given to the situation in order to seek some understanding of what is happening.

> *It's something that I'll probably think about a little bit. I just feel really (---) I feel a little bit distressed for the patient in this. [Rachel].*

This cognitive processing of the situation commonly occurs by nurses self-questioning as to what is happening in a particular circumstance to determine what is causing the emotional or physical response being experienced.

> *It's uncomfortable, but then I tend to just go to work it out to a point where it's not as uncomfortable. Like I'll think it through and work out what I think*

> *… 'why is this making me uncomfortable, why?' 'what is it about this situation that's different from any other situation that I'm uncomfortable with this situation?' . [Kylie].*

The embodied responses and related cognitive processes bring awareness to nurses that their values/beliefs are being challenged and initiates, for them, the possibility that there is an ethical problem. Failure to identify the existence of a problem would be considered a failure in one's duty as a nurse.

> *I never want it to not disturb me because whenever I think it doesn't disturb me it's time to get out. [Meagan].*

Being disturbed by incidents is considered an important indicator that something is not right. Nurses need to recognise this discomfort is an essential part of their role because it then alerts them to the need to take action. The action needed will depend on the decisions made as they proceed through the process of determining their duties when their personal values and belief systems are challenged.

Recognition that the embodied responses could signal the existence of an ethical challenge can be used to enhance ethical sensitivity. Nurses who possess ethical sensitivity are alert to feelings of discomfort or disturbance but they also recognise such triggers require reflexivity to clarify both the situation and their response to it. If nurses simply dismiss these initial symptoms of unease or concern they risk accepting actions or conditions which are immoral or ethically problematic. This can result in moral blindness or indifference (Johnstone, 2004).

The link between the ability to recognise that one's personal values/beliefs are being challenged, and being self-aware, is a two-way link. Once a nurse becomes aware of how he or she actually recognises such challenges, self-awareness is enhanced. Similarly, the development of self-awareness and any modifications that may occur to personal values/beliefs over time, feeds back into enhancing one's ability to recognise the existence of ethical conflict.

> *I can now say 'didn't like that because'. And so I can now put value on that and so put words and understanding as to why I didn't like that. And so it then grows and you can identify. [Katelyn].*

> *Nursing obviously brings it to your, you know certain things it brings to your attention that you probably wouldn't think of if you were working in [a supermarket]. [Mikaylah].*

> *Your past experiences and what you've experienced certainly comes into your judgements in ethical situations. [Emma].*

It is evident that nurses need to be aware of the way they individually determine they are not ethically comfortable with a situation. Further, they need to acquire appropriate skills to properly identify the ethical components in any situation. This is crucial if they are then going to effectively follow through with a process to deal with any challenges to personal values and beliefs that may ensue.

Knowing personal values/beliefs

Being self-aware also involves knowing one's personal values and beliefs. Recognising which values and beliefs are being challenged is important to appropriately deal with ethical situations encountered. Additionally, an awareness of the values and beliefs that would guide one in appropriate behaviour is necessary for effective ethical decision-making. Also knowing which values/beliefs are core, and should therefore be given priority consideration, assists the nurse in better understanding why he or she is feeling challenged. Such knowledge is important when determining how to deal with ethically challenging circumstances.

> *It's important to know what our values are because then we know what is ethical behaviour for us ... and we know what those ones that are close to our own hearts…. I think that's really important, self-knowledge. I mean it's written ... 'know thyself'. Absolutely, oh yes, that is the strategy I think of all. [Krystle].*

Acknowledging that not all values/beliefs impinge on their practice is also beneficial to nurses. It gives them better understanding of which values/beliefs are more likely to be challenged in the work environment and which are unlikely to be affected. For example, a nurse may value 'pacifism' and believe that active participation as a war combatant is wrong. However, such a value is unlikely to be impinged upon in normal nursing practice. In contrast, the 'sanctity of life' value strongly encroaches into nursing practice and is open to situational demands, making it highly likely nurses will encounter circumstances requiring them to make decisions

related to that value. Whether or not they are prepared to compromise those values is something necessitating serious reflection as part of the process of self-awareness.

> *There's values that I won't compromise but they're not values that I would consider affect the nursing practice I have. It's the values that play a part in my nursing practice I feel are values that, they're not transient, but there's a little room to move depending on what's happening. [Tim].*

For example, a nurse who values the sanctity of life may conscientiously object to participate in an abortion procedure, but may respect a patient's refusal for cancer treatment when the benefits of therapy are uncertain and the side effects severe. Self-awareness of how he or she would weigh the values and beliefs that apply in different situations better prepares a nurse to reflect on such dilemmas and to ethically justify the decisions made.

Along with understanding their own values/beliefs nurses need to also acknowledge that other people they encounter in their work environment, including clients and professional colleagues, have value/belief systems and these may vary from their own. People "enter into situations, with their own sets of meanings, habits, and perspectives" (Benner & Wrubel, 1989, p. 23). Nurses form therapeutic relationships with clients from diverse backgrounds who have their own particular beliefs and values and these need to be respected.

> *We then come together and we offer care to individual people who will have a variety of beliefs and of values. [Katelyn].*

> *Nurses have to understand their belief systems ... and they have to understand that other people have different belief systems ... so an understanding of belief systems helps you understand where other people are coming from and the implications of that. [Jade].*

Nurses find themselves in situations where they have to decide what is to be done when values or beliefs of different parties are incongruent. Very often this will require a decision to be made as to whose values/beliefs should be given priority. Having clear knowledge of one's own values and beliefs helps to identify situations where they vary with those of others, as well as giving greater ability to determine whether or not there is preparedness to make any compromise.

Knowing about valuing client autonomy

Data in this study indicate that, overwhelmingly, the participants primarily refer to the value of respect for client autonomy and the part it plays in their ethical decision-making process. Of all the values and beliefs identified, this one was paramount.

> *A fundamental belief in the dignity and the autonomy of people to make their own decisions, and I support that ... a fundamental belief in, or respect for people's ability to make decisions regarding their life, apart from when they're determined to be mentally ill. [Meagan].*

> *Wanting to make sure that any health care decisions that I'm involved in I know the patient is always informed and is the one in control in making the decision. [Rachel].*

> *Autonomy seems to always win out though ... it's about choice, it's about giving information and letting people make choice [sic]. [Kylie].*

When nurses are prepared to give such weight to clients making their own decisions, they also need to be prepared to accept that at times their own preferred choices will have to be compromised. Awareness, by self, that this is happening and how they can justify such a situation to themselves is important if ethical comfort is to be maintained.

Respect for the decisions individuals make for themselves was highly valued by the nurses in the current study, particularly in situations where they believed this right was being compromised.

> *People should feel empowered to make their own decisions, and in this job that's what I see is my value. And it's about that I'm being non-judgemental, being supportive I suppose, of any decision that is made, as long as it's made by the client. [Kylie].*

> *The client's own ideas should come first and the other consideration should, you know they've got a place and come second. [Austin].*

Nurses who are aware that, for them, client autonomy is a priority value are likely to be ethically challenged in situations where they believe insufficient eminence is being given to clients' autonomous choices. However, the use of terminology such as 'being non-judgemental', 'being supportive … as long as it's [the decision] made by the client', and 'the client's own ideas should come first' exposes the possibility of abdication of any moral responsibility. Unless nurses have clearly identified for

themselves where they place the value of protecting client autonomy, why it is given such ranking, and where it fits in overall with their values and belief system, it could simply be tantamount to accepting that 'the customer is always right'. Such a situation risks relegating client autonomy to a position of blindly accepted obligation rather than one of recognised moral value. Self-awareness of the ethical reasoning used to justify giving respect for client autonomy such prominence is necessary to avoid simply consigning it to a mandatory position.

Knowing about other conflicting values

Although autonomy may be given primary regard, there are other values/beliefs to which nurses are committed. It is, in part, because they are so strongly held that ethical challenges occur. Commitment to multiple values can at times occur simultaneously. However, if the values to which the nurse wishes to maintain a commitment are divergent, or in opposition to each other, an ethical dilemma results (Johnstone, 2004). This then requires a choice be made between the conflicting values.

An example of a situation where a nurse may be required to make a choice between conflicting values is where he or she is committed to the values of respecting client autonomy and the sanctity of life. An ethical dilemma may arise for the nurse when a client chooses to have a termination of a pregnancy because it is not possible for the nurse to maintain commitment to both values simultaneously. If priority is given to client autonomy then the value of the sanctity of life has to be sacrificed in that circumstance. Weighing the client's right to self determination, as in the case of abortion, against personal commitment to sanctity of life that sees the act of abortion as wrong, involves personal discomfort. When an acceptable compromise is defined, as in the example below, both values may be upheld, if not entirely, then at least as far as the individual nurse's involvement is concerned.

> *I did look after a woman who had an abortion. Yes it was difficult, but the way I resolved it was I didn't actually do the procedure. So I wasn't responsible for the abortion. I was responsible to care for a woman who had been through a difficult time. [Jade].*

Both the reasoning and the actions of the nurse in this example indicate how a nurse may resolve an ethical dilemma, distancing oneself from morally unacceptable acts of

others, while retaining a sense of caring and moral integrity. The nurse acts in light of deontological principles but injects the ethic of care into the situation, recognising the human frailty of the woman requiring nursing care and providing her with the care needed rather than giving moral censure.

A similar stance may be taken in regard to prolonging life. Nurses may hold to the values of the sanctity of life and respect for the dignity of clients. However, in some circumstances they may find these values in conflict and so are required to weigh up which one will be given priority in the situation.

> *Even though I think it's [life] sacred I don't think you should prolong life ... dignity is an important issue, value, and I value life, I value dignity. [Emeline].*

> *I think it's important to understand that death is part of life, because you don't [then] unrealistically flog away at something, or don't encourage others to. Like someone with resuscitation, you don't just jump on everyone's chest. You recognise there's a time to say no. [Jade].*

The process of balancing conflicting values against each other in such situations, so a decision can be made, is one that requires the nurse to be aware of the particular values at play in the situation. Unless they are clearly identified the nurse's ability to decide which one should be given priority over the other/s is limited.

When nurses identify values they consider are important in their professional environments, client autonomy is often given priority, particularly when values need to be balanced against each other. However, care and compassion for the client are also values nurses believe are highly important.

> *Compassion [is] number one. Treating somebody how you yourself would want to be treated in that situation. Respect for that person's dignity and for his request, his or her request. [Michelle].*

> *To respect people's right to independence and personal dignity ... to have their own, you know, wishes respected is important I think, and that comes down to, you know, people being humanely treated. [Austin].*

> *I'm, you know, one that goes for the real caring element ... it really falls down to the respect that you have for that person ... to maintain their privacy, their confidentiality, promoting their independence and promoting their dignity. [Holly].*

These values are often linked to respect for client autonomy because it is care and compassion for the person which often motivates nurses to want to allow clients to make their own decisions. This will be discussed further in Chapter Nine of this thesis.

Nurses who cannot identify which values or beliefs are involved in ethically challenging situations are not self-aware and are limited in their ability to effectively deal with such situations. The phase of 'knowing personal values/beliefs' requires nurses to clearly identify for themselves the values and beliefs to which they hold and how they would prioritise them. In order to weigh up conflicting values and make a decision about which ones will be maintained, and which ones can be willingly compromised, requires clear knowledge and awareness of the pertinent values and beliefs.

Understanding influences on values/beliefs

Knowledge of the influences that have helped develop an individual's values and belief system assists in self-awareness because it helps to identify and develop understanding as to why one may think a certain way about, and respond in a particular way to, situations. Additionally, it helps an individual understand why they may modify or change certain values or beliefs over time. Personal and professional aspects of an individual's life, along with broader social and cultural influences can impact on the values and beliefs held. To maintain self-awareness it is important that nurses recognise such changes can occur and are conscious of the triggering influences.

Personal influences on values/beliefs

There are various people and experiences in an individual's personal life, as opposed to their professional life, that can influence the values and beliefs held. In particular, individuals' families and the environment in which they are brought up can influence values and beliefs, especially during childhood and adolescence. Once they become adults, personal experiences, both good and bad, along with the people who are significant to them personally, can continue to have an effect on values and beliefs.

A major influence on the development of an individual's values/beliefs comes from their actual upbringing and their family.

> *I do believe that it's your growing up experience and I guess that has to affect your behaviour and your values. [Mikaylah].*

> *I don't think I'm born with that. It's something I've learned from my parents' particular values of people. [Amanda].*

> *I think the decision-making will be ethical decision-making that I'm part of, whether it's subliminal or conscious, would have to be underpinned I think by the upbringing I've had and even if I choose to agree with it or oppose it. [Alisa].*

Religious experiences also impact on values/beliefs and are often linked to upbringing, family influences, or past experiences.

> *If one has grown up with fairly strong religious principles then I think the basis of the value system is fairly well founded. [Nathan].*

> *I would call myself a Christian person so that very much forms ... that was formative in my personal beliefs and values system. [Katelyn].*

> *Well I think some of it is from you know my religious system. I am a Christian so that would definitely bring about some of those values. I think some of it is environmental and family set-up. [Holly].*

Personal life experiences, even once an individual becomes an adult, continue to influence one's values/beliefs.

> *I think my own life experiences. I think having children, marriage, having parents die. [Belinda].*

> *I think they're [values] things that develop and change. I still have some core values that I had from my family ... but I think I have different values about people than I had from my family and that's due to changes in my journey and the people I've met as an adult. [Meagan].*

Part of being self-aware means understanding that these personal influences can impact on nurses in the work environment. Realising that it is generally a clash in values or beliefs which cause ethical discomfort gives the nurse better insight into what should be given focus when dealing with the situation.

> *I've always been raised with that certain things are a mortal sin and should never occur. And so therefore very often I have to take, if I'm starting to feel*

> *uncomfortable, I have to look at that and I think that's where it's coming*
> *from. [Lauren].*

Nurses, as part of the process of self-awareness, need to recognise they exist in a pluralistic society. Health-care clients will have their own values and beliefs and these may not always align with those of the nurse caring for them.

> *We then come together and we offer care to people who have a variety of*
> *beliefs, of values…. We're individual people and we come into that in a*
> *situation of crisis and providing care…. We must think beyond that. I think it*
> *calls us to very much have to be in touch with who I am as a person in my*
> *area of power. [Katelyn].*
>
> *They come from their backgrounds with their sort of beliefs and they, you in*
> *turn, and they should respect mine and I should respect theirs. So, and I think*
> *that's what's the most important thing about nursing. It's looking at people as*
> *individuals and not saying that you should do this and you should do that just*
> *because I feel that it's right. [Lauren].*

In such situations, the identification of any differences in values and beliefs, and seeking ways to manage them, is essential. Because individuals choose to hold onto certain beliefs and values they obviously consider them important and right. This brings with it a risk of inherent ethnocentrism. If nurses fail to recognise the personal influences that have resulted in them having their particular set of values and beliefs they limit their ability to appropriately deal with situations where they encounter people with different or opposing views.

Professional influences on values/beliefs

In addition to personal influences, professional nursing experiences can also shape the values and beliefs of nurses.

> *A lot of who I am as a person around my values has also come from nursing,*
> *and my exposure to nursing … so many things I decide on today are [an]*
> *accumulation of the experiences I've had as a person but also as a nurse.*
> *[Meagan].*
>
> *Simply because as I mature in my nursing career I don't see things as black*
> *and white as I did as a young person. [Cameron].*

At times, challenging nursing experiences may force them to reassess their values/beliefs and how they would weigh them. Maturity and simply being exposed to the nursing environment can also result in them making modifications, especially in terms of considering some issues with a more open mind than they once did.

Other influences

Broader social and cultural influences such as expected group norms or customs can also influence the personal values and beliefs one holds (Fry & Johnstone, 2002). Additionally, the impact of the media on values and beliefs, particularly those related to issues about life and health which nurses regularly encounter, cannot be discounted (Wagner & Ronen, 1996).

The study participants identified personal and professional influences as the predominant factors which influenced the values and beliefs they currently held. There was acknowledgement, albeit limited, that broader social and cultural influences also had an impact.

> *Some of it is environmental ... some of it is cultural and you know, I'm in a Western culture where we do tend to value human life significantly. [Holly].*

> *In my country you have to respect people older than you are ... you don't use bad words regardless whether the personal is abusive or something ... that's not acceptable because of the repercussion and sign of disrespect. [Yasmin].*

The way is which personal and professional experiences have influenced the development and maturing of values and beliefs over time is recognised by nurses who are self-aware. However, data in the current study indicate that the effect from broader influences was not readily acknowledged by many of the participants.

Other research related to being self-aware in ethically challenging situations

The finding in this current study that being self-aware is an important part of the process of dealing with ethical challenges to personal values and belief systems are consistent with those of Varcoe et al. (2004). In their study of student and practicing nurses in Canada they found that nurses evolve into the role of moral agents and a developing understanding of themselves and how they personally deal with ethical issues is important to this process. Becoming a moral agent depends on personal knowledge, along with education and nursing experience. Similarly, Altun (2002) reported that self-awareness promotes a well-informed understanding of one's personal values and beliefs and can actually help reduce conflict when making decisions because the individual better understands the influences on his or her

behaviour. Altun (2002) asserts that "nurses must maintain a high level of self-awareness, which begins with personal reflection and understanding of their own values and beliefs" (p. 277).

Reflecting on nursing experiences identified as being personally meaningful has been found to assist nurses develop their self-understanding and to gain greater self-awareness. Drew (1997) suggested that "nurses who understand and explore the meaningful experiences that define them have begun to move toward expanded self-awareness and a clearer understanding of the values that influence their practice" (p. 421). Wessel and Garon (2005) reported that the use of written reflective narratives has been found to be a beneficial strategy to assist nurses develop self-awareness. The strategy promotes critical thinking about situations and encourages reflection on attitudes and experiences so that meaning in them can be found. Similarly, Lemonidou et al. (2004) reported that written narratives are beneficial to nursing students in developing self-awareness, particularly in relation to personal values and moral awareness.

The finding in the current study that nurses use emotional responses to identify they are troubled by ethical situations adds to the observations of Wurzbach (1996) who found nurses experienced discomfort when they questioned if they had done the right thing. Her study also found that nurse used an inner sense of peace to help confirm they had made a right decision or had acted ethically. The current findings also add to the results of a study of nursing students in Greece where it was found they used emotional feelings to validate the existence of an ethical incident. The students indicated the feelings of uneasiness, or "not feeling right" (p. 125) as cues to ethical concerns, rather than a cognitive recognition of conflicting ethical values or principles (Lemonidou et al., 2004).

Other studies have also identified the emotional and physical responses experienced by nurses as a result of situations that have caused ethical dilemmas, or when they have been unable to follow through with their chosen option in an ethical situation (Corley, Minick, Elswick, & Jacobs, 2005; Severinsson, 2003; Sundin-Huard & Fahy, 1999; Wilkinson, 1987; Zuzelo, 2007). The outcome for nurses in

these circumstances included moral distress, stress, or burnout. Whilst acknowledging these studies identified the existence of embodied reactions, the current study is different in that it identified these as initial cues that values/beliefs are being personally challenged, rather than reactions once the existence of an ethical problem has already been identified.

Research evidence reporting the actual values and beliefs nurses consider important is limited so identification in the current study of a particular value being given priority consideration adds to nursing knowledge. There is evidence from other studies that nurses give high consideration to the various values identified by the participants in the current study, although the focus of these studies was on identifying situations that cause nurses ethical concern or conflict, rather than specifically identifying the values to which they are committed (Chally & Loriz, 1998; Gold et al., 1995; Johnstone et al., 2004; Raines, 2000; Redman & Fry, 2000). Nevertheless, it is acknowledged these are ethical issues where the values of autonomy, care, compassion, and respect for the dignity and welfare of clients are likely to play a crucial role.

The finding that religion influences one's personal values and beliefs, and these in turn can impact on them in their professional roles, adds support to observations made by Cassells and Redman (1989). In identifying the sources that nurses, in the six month to one year period after graduation, perceived had helped them in developing their abilities to make ethical decisions, they found that two thirds of respondents identified religious influence as a source. This came second only to "group discussion of ethical dilemmas with colleagues/peers" (Cassells & Redman, 1989, p. 471). The finding that personal life experiences also impact on one's values and beliefs concurs with conclusions by Joudrey and Gough (1999) who reported that the subjects in their study identified family as the major influence in the development of their ethical values. Religion was listed second, followed by peers and then nursing instructors. Their subjects were nursing students rather than graduate nurses; however, the current study provides further support for the strength of influence that family and religion can have on the development of personal values.

The current study found that actual nursing experiences can result in nurses re-assessing their own values and beliefs, with some actually modifying them as a result. This supports conclusions by other researchers, including du Tont (1994), who found nursing students undergo a transformation process "during which the values, norms and symbols of the profession are internalised" (p. 164). This can result in modification of personal values even within the novice nurse. B Kelly (1998) found that many new graduate nurses altered their ethical values during their first two years of working as graduate nurses. The amount of change depended on the level of similarity between the nurses' personal values and the values in their work environment, along with how much the new nurses were prepared to accept the institutional and team values as their own. Similarly, Schank and Weis (2001), when studying how senior nursing students and practicing nurses rated the importance of behaviours that reflected the values in the *American Nurses Association code for nurses*, found there were differences between the two groups. The senior students gave less importance to the behaviours which were reflective of the code than did the practicing nurses, providing evidence that professional values continue to develop as new graduate nurses gain more experience. From a study of nurses caring for clients who were living with suffering, or were dying, Maeve (1998) reported that "the moral strands of practice were interlaced into the nurses' everyday lives, both personally and professionally" (p. 1140). She found that not only did the nurses have an impact on clients as they cared for them, but nurses were themselves affected by the experience at a personal level. The influence on the nurses was at times profound, with some making major changes to personal aspects of their lives as a result.

Summary

In this chapter I have described the first category in the substantive theory, that of **being self-aware**. It is evident from the data that nurses need to be self-aware to effectively identify and deal with ethical situations which personally challenge them in the work place. The first phase of this category involves nurses recognising a situation encountered, that has ethical components, is causing them discomfort. This often occurs through an embodied sense, whereby they experience physical and emotional feelings that alert them to a problem. Once nurses recognise an ethical challenge exists they need to know which personal values and beliefs are relevant in

the situation. These will be more readily identified by nurses who are self aware because they know the values and beliefs to which they adhere.

Being self-aware is an on-going process. Both personal and professional experiences can impact on personal values/beliefs, and as a result there can be an emerging change in the self. Such changes may be profound and obvious to the person. However, the modifications may also be subtle and develop slowly over time. Strategies are needed to ensure self-awareness is maintained on a continuous basis. If personal values and beliefs are clarified nurses are able to identify which ones are affected in a particular situation, and why they are feeling uncomfortable. Understanding the factors that have influenced the values and beliefs held, how they have modified over time, and what has caused any changes, assists in self-awareness.

In Chapter Six, I give a detailed description of the second category in the process, **determining duties to other/s versus self**. This describes the processes nurses use to determine how they will respond to ethical situations in the work place that personally challenge them.

Chapter 6

Determining Duties when Ethically Challenged

You're focusing on patient care and you're caring for human beings. You need that ethics side so you can decide what is right or what is wrong for that person, and also for yourself. So if you're given a direction that you do feel uncomfortable with, you do, you can turn around and say I don't feel right about this. Is this ethical for the patient? Or is this ethical for myself as a nurse to be able to do what I'm being asked to do or to act the way that I'm being asked to act? [Carlee].

Once nurses recognise they are being ethically challenged, various options are open to them. They could choose to just avoid the situation and walk away from it. However, if they are aware of an embodied response which has made them sense an internal conflict it is unlikely that just ignoring it will assist in resolution of the dissonance. To resolve the discord there is a need to move through a process that requires them to consider, and respond to, the challenge to their personal values and beliefs. Failure to do so can impede their ability to carry out their caring role.

Chapter overview

In this chapter I explain the second of the four categories that describe the processes used by nurses when their personal values/beliefs have been challenged in their professional environment. This category, **determining duties to other/s versus self**, involves nurses making decisions about how they will respond to the challenge. Two major phases occur: (1) **positioning client as decision-maker**, and (2) **positioning self as moral agent**; both will be described in turn.

Category 2: Determining duties to other/s versus self

When nurses are ethically challenged, data in the current study indicate they go through a process of determining what their duties are, as they perceive them, to any others involved in the situation, versus the duties they have to themselves. Duties in the context of this category relate to ethical obligations perceived to exist in an ethically problematic situation. In such situations, nurses make a decision as to whether client autonomy can, or should, be considered and whether it can be protected. They give focus to client autonomy during this process because it is the

value generally given primacy. Additionally, nurses consider the ethical responsibilities they have to themselves and whether they are comfortable with modifying the weighting they would normally give particular values and beliefs. Throughout this process, nurses' responsibilities to clients remain a major focus.

Two phases come into play when a nurse determines duties to other/s and self: positioning client as decision-maker, and positioning self as moral agent. During the phase of positioning client as decision-maker, a nurse gives consideration to two major issues: (1) the nurse's power to protect client autonomy, and (2) the nurse taking measures to not impose his or her own opinion on the client. When positioning self as moral agent, two major matters are considered: (1) identifying what the nurse perceives are ethical responsibilities to self in relation to personal values and beliefs held, and (2) deciding whether particular values and beliefs are relevant to the situation, and if so, how they should be prioritised. These are all discussed in detail following Figure 6.1.

The coloured sections in Figure 6.1 below illustrate how the category of 'Determining duties to other/s versus self', and its various phases link together, and where they fit into the substantive theory.
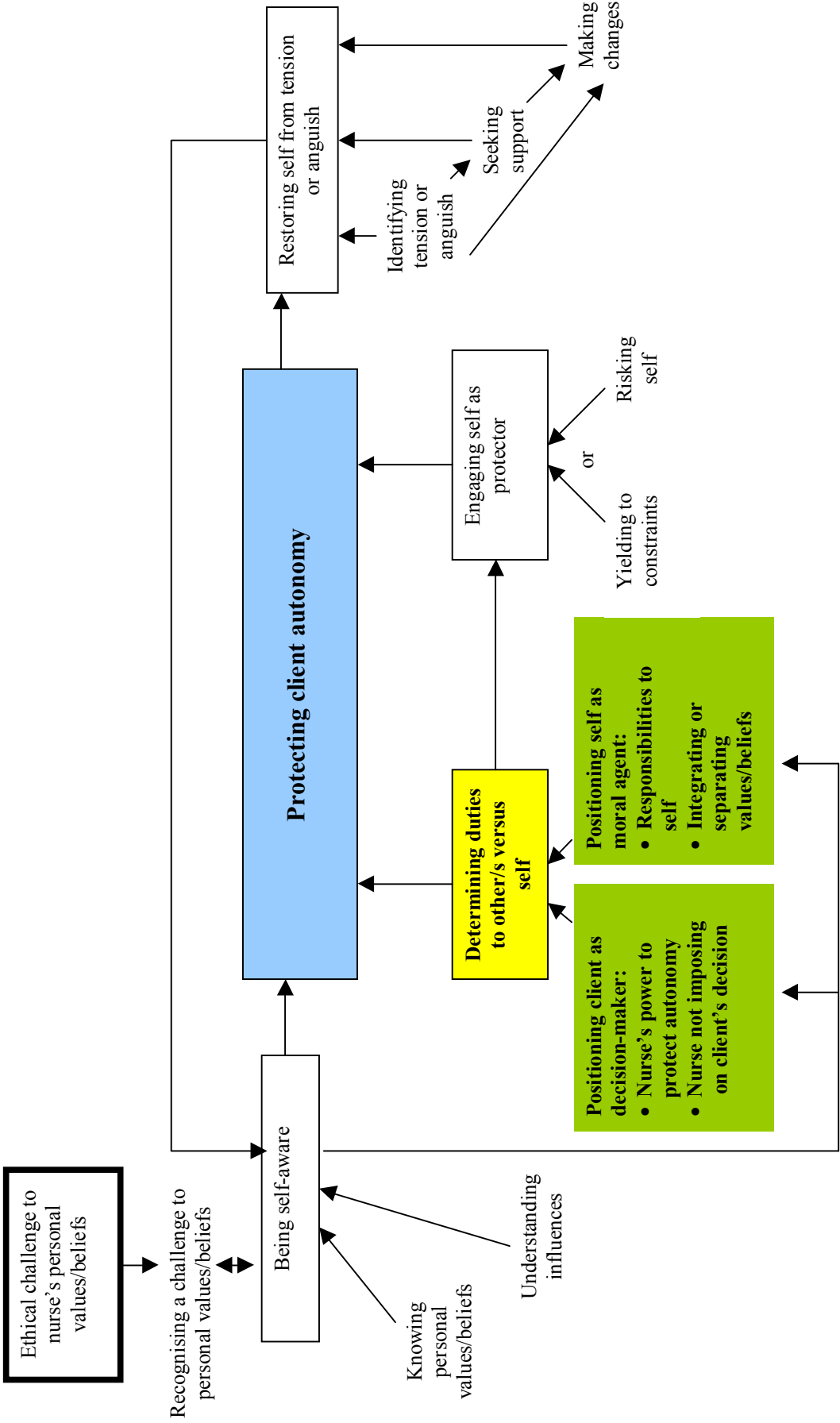
Figure 6.1: Category 2 – 'Determining duties to other/s versus self' and its place in the theory

Positioning client as decision-maker

When nurses, usually through sensing an embodied response, recognise that particular values or beliefs are being challenged they proceed through a decision-making process to determine if they will take action and, if so, what it will be. Legal ramifications are also considered, with nurses being conscious of the need to practice within the confines of the law.

I would have responded in favour of the patient's decision until it was obvious that the legal implications might put my ability to continue nursing at risk. [A response to Vignette 2].

Then there's legal ramifications for nurses. So it's really hard sometimes balancing what the resident wants, the residents' choices, their first charter of rights, and what you need to do legally. [Emma].

Nurses who value client autonomy will take steps to give it precedence. They are willing, if it is in their power to do so, to allow clients to be the primary decision-makers in relation to healthcare choices. Various constraints may prevent this, but nurses will usually consider ways of allowing it before acceding to such constraints. There will be occasions when, because of differing values and belief systems, clients make decisions that are contrary to what nurses themselves believe should happen. Data in this study indicated that only on rare occasions will nurses give priority to their own value/belief based choices, over those of the client, in such situations.

There was clear evidence in the study data that participants gave precedence to the ethical principle of client autonomy, over other values. Situations exceptional to this were not common and generally occurred only if it was considered legal implications were dominant, the decisions of significant others required due respect, or client care would very likely be compromised.

I think that the interests of your client have to be considered firstly and the interests as they see them … you know seek out what this person's plans for themselves are and try and assist them along that path. [Austin].

Ultimately it's the patient's decision. I cannot force a person to do something against their will and I have to accept in my mind, and maybe this comes with maturity and age, that this is the right thing unless they're in danger of hurting themselves or other people then that could be different. [Belinda].

Giving priority to the autonomy of clients and their right to make decisions and choices for themselves is identified by the nursing profession as an important ethical responsibility. The *Code of ethics for nurses in Australia* gives focus to this in the second value statement: "Nurses accept the rights of individuals to make informed choices in relation to their care" (ANMC, 2002, p. 3). This is especially pertinent in a pluralistic society where it is usually inappropriate to make assumptions about what clients consider is beneficial or harmful to their situation (Obeid, 1997), and where the values and beliefs of nurses and clients can be different or even opposing (Tompkins, 1992). However, the term used in the code is 'informed', not just 'any' and this requires deliberation. Choices made by clients must be informed and nurses have an ethical responsibility to ensure they are sufficiently knowledgeable to allow reasoned decisions to be made.

Although focussing specifically on situations involving the withdrawal of life-sustaining treatment, Pellegrino (2000) contends that:

> … patients with the capacity to make the decision in question are the morally valid decision makers. Patients with the capacity to give authentic authorization have both moral and legal authority that, within certain boundaries, overrules the wishes of the physician, the patient's surrogate, or family. (p. 1065)

Nurses who choose to give precedence to client autonomy when dealing with situations that challenge their own personal values and beliefs, recognise clients "are the morally valid decision makers" (Pellegrino, 2000, p. 1065) with the right to make their own decisions (Pelletier et al., 1997). They accept that health care clients have the right to have control over what happens to them (Singer, Martin, & Kelner, 1999).

If a client's autonomous decision is different to what the nurse believes ought to happen, this should not simply be viewed as a situation that is contrary to a nurse's values/beliefs. The fact that the client has had opportunity for self-determination is still congruent with what nurses value and desire for their clients, albeit with associated risks. Rating client autonomy as having highest priority not only runs the risk clients may make choices that are uninformed, irrational, impulsive, or

incongruent with a nurse's or others' values/beliefs, but they might also be contrary to the best interest of patients. Nurses are at times prepared to run such risks because of the priority given to client autonomy. In some of the experiences shared by the participants in this current study, this is what occurred. Choices made by clients may then have resulted in further ethical challenge for the nurse if it meant other values/beliefs were in conflict. The nurses were usually prepared to accept such circumstances, gaining moral comfort from the fact that they had allowed client autonomy to remain the dominant value.

By 'client autonomy' the participants meant the right of clients to make choices for themselves, usually in relation to their health care and therapy, based on the clients' values, beliefs and circumstances. This right to make choices was applied more broadly than to client need only, with references to client wishes, interests and wants also being made. However, it is acknowledged these terms are not synonymous. Whereas a need refers to something which is required by necessity, the terms wish, interest, and want usually represent something that is desirable or preferred but not necessarily required. A distinction between these various terms was not clearly evident in the data so the use of the term 'client autonomy' in this thesis is applied to choices made by clients that encompass these various categories. This will be discussed further in Chapter Nine of the thesis.

Nurse's power to protect client autonomy

Whether nurses are able to give primacy to client autonomy, and to put them into the position of decision-maker, will often depend on the level of influence nurses have in the decision-making process. If nurses are excluded when decisions related to clients are being made, the opportunity for them to ensure that client autonomy is considered is limited. The level of involvement, and therefore influence, by nurses can vary depending on the type of ethical situation, who the players are in the situation, the particular workplace, or even the time of day.

> *It depends on the situation. Sometimes I feel I have some sort of input into what actually happens because I work within a team. And sometimes I'm valued and sometimes I'm not valued. And sometimes my opinions are valued and sometimes they're not ... I think that nurses most of the time do try to be active in all those decision-making process with the client, and I think that they, the actual patient, rely on us. [Lauren].*

It depends entirely on the clinical area in my experience, and what position I'm in ... in senior management I perhaps had less control over the decisions because I was a stepping stone or a buffer to other things ... probably the one area where I had the most power was in intensive care and certainly in mental health because you make decisions around everything and it has a big impact on people's life ... so you know it really depends on the area and the ability to develop relationships with those in power. [Meagan].

So that was a dilemma for me and I wasn't happy about it. But I was working night shift so I wasn't able to voice my opinion.... It's the doctor and the client. But the nurses should be involved because they're the ones who have to carry things out usually. [Jade].

Whether nurses have the power to protect client autonomy is usually circumstantial. If they become aware that clients' autonomous choices are being neglected they may actively attempt to reverse that, but whether or not they succeed will often depend on others in the situation allowing it to occur.

So that was a reasonable outcome but it was pretty hard going. Really hard going in fact just in terms of making sure that her needs got met and all. [Rachel].

The challenges posed by ethical situations are compounded when nurses are restricted in their involvement in ethical decision-making and dealing with ethical problems (Liaschenko, 1995). This further constrains their ability to protect client autonomy.

I didn't feel like I had any choice. I could jump up and down and yell and scream all I liked, that wouldn't have worked ... all their hands were tied, unfortunately at the end of the day they had to do what the person responsible was requesting. [Emma].

We don't have the power that say the medical side have. They, I mean we do have power but our power is that it's not perhaps as strong as other health participants... I think it's completely wrong... and things happen and in our management in our hospitals and thing that we don't like, and we can do nothing about it because we've got no say. [Angela].

Wilson-Barnett (1986) warned back in the 1980s that nurses needed to be given greater opportunity to be involved in decision-making in relation to client care, particularly in relation to ethical issues. There is evidence in the current study that such opportunities are still limited in some settings. When nurses see themselves as

protectors of client autonomy they want to be involved in the decision-making process to ensure the client is appropriately heard. However, clear processes or procedures allowing this to occur are not always apparent.

Nurses who value client autonomy may at times encounter situations where clients are unable to make their own decisions. In such situations nurses caring for them may believe they should have an active role in the decision-making process, particularly because they consider they are more knowledgeable about the client. They are not always afforded this opportunity. Haddad (1995) argues that:

> Nurses – more than any other caregivers – are privy to their patients' fears, hopes, and values. Often they're the only health care providers who know all the players in an ethical conflict. Yet they are generally excluded from ethical decision-making regarding their patients". (p. 22)

Norrie (1997) points out that nurses who care for critically ill clients are with them constantly, making decisions about their care which are at times very complex; yet they often have limited involvement in ethical decision-making. Melia (1994b) supports the view that nurses are "more constantly with the patient than are other professionals … [and therefore] have some view of what life is like for the patient" (p. 22). This gives nurses opportunity to be knowledgeable about patients' perspectives. However, Melia (1994b) also warns "this vantage point should not be over-stated; only the patient knows the patient's view" (p. 22). Bennett (1999) concurs with this notion, postulating there is potential for abuse when nurses make the assumption they know what the patient wants. Protection of client autonomy requires a nurse to be clearly knowledgeable about what the client's autonomous decision is.

> *You do a big part in the decision-making process and often you know what you say is what ends up happening. The doctor comes in and says 'Oh what do you think we should do?' And so you do have a responsibility for your opinion, and for what the results are of it. [Austin].*

To ensure they clearly understand the client's viewpoint, nurses, when given the opportunity to be involved in decision-making need to do so *with* the client rather than *for* the client so that client autonomy is protected. Failure to do so compromises the advocacy role of the nurse in such situations and this will be discussed further in Chapter Nine.

There is strong evidence in the current data that nurses who value client autonomy want to ensure it is protected, with clients given the opportunity to make choices which are informed and reflective of their own values, beliefs and circumstances. However, because nurses are not always themselves given the opportunity to be involved in the decision-making process they find at times they are unable to protect client autonomy. This can, in itself, be a cause of ethical discomfort or it can add to an already existing challenge. Where they can be involved in decision-making it needs to be carried out responsibly because of the consequences to the client.

Nurse not imposing on client's decision

When respect for client autonomy is given priority nurses will avoid imposing their own choices on to clients. This, they consider, is crucial to the process of protecting client autonomy.

> I think [I] believe in the inherent worth of individuals and ... the right of the individual to make choices, so that's sort of important I suppose in when I'm making decisions I try to centre the decision on what the individual would want as opposed to what I want.... I think if you go with what the individual decides and try not to put your personal values to sway them one [way] or another then you can very comfortably be professional with whatever their decision is. [Emma].

> Then separating that from who the person is and not pushing myself and my beliefs on to that person, but appreciating that they have individual beliefs and thoughts. [Katelyn].

> My beliefs or values should not impinge on the choice the patient has made. [A response from Vignette 1].

That nurses believe they should not impose their own choices or preferences on clients is in keeping with the *Code of ethics for nurses in Australia* (ANMC, 2002). Of particular relevance are the first two value statements in the code: (1) "Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care" and (2) "Nurses accept the rights of individuals to make informed choices in relation to their care" (ANMC, 2002, p. 3). Nurses need to be sensitive to the beliefs of clients, and ensure they discriminate between their own views and those of their clients. Pask (1997) suggests this may, at times, be difficult to do, particularly

in circumstances where the nurse has no personal experience of the issues involved. Nevertheless, it is an important responsibility of nurses. Being able to develop a therapeutic nurse-client relationship even in situations where each may have a different world view "reflects the moral and ethical knowledge that is the foundation of such relationships" (Tarlier, 2004, p. 239).

Often, out of concern for their welfare, nurses will give clients additional information to assist them in the decision-making process. This occurs particularly in situations where nurses believe clients are making naïve or ill-advised decisions. However, they will usually still allow the client to make the final decision as long as it is within legal boundaries and is unlikely to cause harm, either to the client or to others.

> *Wanting to make sure that any health care decisions that I'm involved in I know the patient is always informed and is the one in control in making the decision. [Rachel].*

Because nurses believe clients need to make decisions that are fully informed they will do what they can to ensure clients have all necessary information. This is in keeping with the third explanatory statement in value statement 2 of the *Code of ethics for nurses in Australia* (ANMC, 2002), which states:

> Illness and/or other factors may compromise a person's capacity for self-determination. Where able, nurses should ensure such persons continue to have adequate and relevant information to enable them to make informed choices about their care and treatment and to maintain an optimum degree of self-direction and self-determination. (p. 3)

Nurses will also engage with the client during the decision-making process and are prepared to negotiate with them. They may, on occasion, even try to influence the client's decision if they believe the client's choice is inappropriate; but having done so are prepared, in the main, to leave the final decision to the client.

> *So I talked to her about the various options she had ... but I respected whatever decision she made and would support her with whatever one it was and left her to think about it with her husband.... So very much about explaining. Totally putting the cards on the table without keeping anything back. [Krystle].*

> *Now I think what I would do in that scenario is lay it on the table, that is these are your two options. This is what we can provide…. But if it was somebody was prepared to die in pain to stay at home I would probably have to go with it. But quite often that, with a bit of chat and a few visits, people can be [sic] that this might be a better way, but it ultimately, it's not my decision, it is the patient's decision and I have to go with that. [Belinda].*

Nurse need to be aware of their values/beliefs and understand their impact on decision-making in order that imposing their own views is avoided in such situations.

Believing they should not impose their values/beliefs on others is also, for some nurses, a means of helping them actually deal with a situation that they find challenging. They readily accept the decision should be made by the client, or the client's significant other/s. Because such decisions are viewed as not being a nursing responsibility, they are better able to accept what is happening.

> *The way I resolved that was that I can't impose my values on the young parents who have to cope with that. [Jade].*

In such situations, the nurses are able to absolve themselves of responsibility for outcomes which are different to what they may have chosen if they were the decision-maker.

Positioning self as moral agent

The second phase in the process of determining duties to other/s versus self involves nurses making a decision as to what responsibilities they have to themselves in the situation and where their personal values/beliefs should be situated in the particular ethical circumstance being considered. This occurs in their role as moral agent. "Moral agency is that property a person possesses of being able to reason, self-determine, and ultimately act or be moral" (Jacobs, 2001, p. 32). Moral agents understand themselves as rational individuals who have confidence in their ability to make moral decisions (MacIntyre, 1999). Nurses are moral agents and they accept they have a moral duty to act. This is recognised in the *Code of ethics for nurses in Australia* (ANMC, 2002) which defines a moral agent as "a person who acts morally / ethically on his or her own authority" (p. 2).

Although some accept that nurses are moral agents (Jacobs, 2001), such a view is not universal. For example, nurses in some settings are subordinates in a

hierarchical system with limits on individual decision-making and discretionary judgment. This prompted Chambliss (1996) to pose the question: "In a setting where one's work is governed by others, how can one person claim her own moral integrity?" (p. 3). It could therefore be argued that institutional requirements and constraints preclude nurses from acting as moral agents. Nevertheless, there is strong evidence in the current study that nurses do "reason, self-determine, and ultimately act" (Jacobs, 2001, p. 32). Although they may not always be able to act in accordance with their opinions, they still follow the process of being moral agents.

There was ample evidence in the data that nurses reason through situations with ethical components, and they determine what to do in such situations.

> *I'd consider what is best for the patient. I'd get his or her opinion and I'd try and fit my practice around their requests. Then I'd consider their family. Then I'd consider the legal implications. [Michelle].*

> *I sort of stand back and look at the whole picture and then look at "if I do nothing what will happen?, if I voice the patient's opinion what will happen?".... I often maybe get somebody else's opinion on what is important and isn't ... but mainly support patients. I say to them "well okay, what do you want?' or 'this is going to happen, are you happy with this?" [Carlee].*

Clients remain the primary focus as nurses carry out this role, and nurses act in line with what they believe is right for the client. Overwhelmingly, they consider the 'right' action is that which gives priority to client autonomy.

Responsibilities to self

During the phase of 'positioning self as moral agent' nurses make a decision as to what their moral responsibilities are to themselves in their role as health care professionals who have responsibility for autonomous clients. This involves ascertaining whether there are personal values/beliefs which they believe must be given precedence and which they are not prepared to compromise, or whether they are prepared to give priority to client autonomy. They are required to determine what their commitment is to their personal values alongside their professional responsibilities (Maze, 2005; Turner et al., 1996). At times these can be in conflict, requiring a choice as to where their priorities lie. Such situations require nurses to choose between their own autonomy and the autonomy of their clients and can be described as "instance[s] of competing autonomies" (Buryska, 2001, p. 119).

Although nurses are predominantly prepared to give priority to client autonomy, within the data there is evidence they also consider their own personal values/beliefs when making ethical decisions. In this process they determine which personal values and beliefs are affected by the situation and whether or not they are prepared to abdicate them in favour of clients' needs and wishes.

> *Nurses also have a duty to themselves and to make sure that they are doing what they feel is right. [Lauren].*

Evidence from the data of nurses being unwilling to compromise their own values/beliefs in order to support client autonomy was limited, especially in comparison to the large amount of data indicating priority being given to the autonomous decisions of clients, or to legal or power constraints. However, there are times when nurses choose to put their own values first, even though they sometimes do so at risk. When such decisions are made they are still made with regard to the therapeutic needs of the client. The study participants clearly indicated they would not be prepared to give priority to their personal values/beliefs if there was a risk of causing harm to the client.

A continuum, along which nurses identify their commitment to personal values/beliefs when they are challenged in the professional environment and consider their options, is apparent. One end of the continuum illustrates the situation where a nurse decides he or she is prepared to abdicate commitment to those values and beliefs. The opposite end of the continuum illustrates the situation where a nurse decides he or she is not prepared to abdicate or compromise strongly held beliefs or values, rather they are asserted. Between those two extremes exists situations where a nurse may decide to alter the way in which his or her values have previously been, or are currently, weighted so that client welfare or autonomy is not compromised. This involves a process of personally negotiating the way in which values and beliefs will be weighted in the given situation. Figure 6.2 below illustrates this continuum.

Personal values/beliefs abdicated | Personal values/beliefs negotiated | Personal values/beliefs asserted
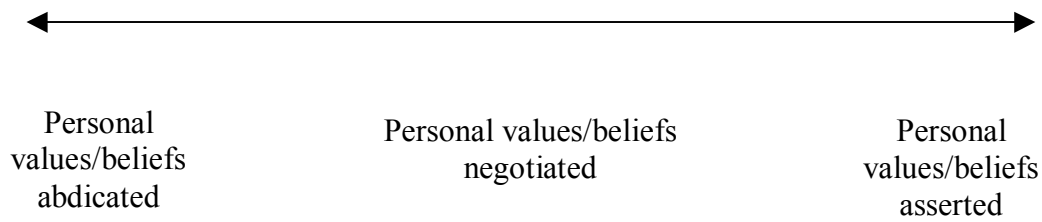
Figure 6.2: Commitment to personal values/beliefs continuum

The abdication of specific, previously held, values and beliefs occurs when a nurse accepts that they are now no longer relevant, or have been held in error. This can result from experiences, either personal or professional, that cause nurses to reflect on what their current understanding and reality is, making them become conscious of the need to make modifications to some of their values or beliefs as a result.

> *I still have some core values that I had from my family…. But I think I have different values about people than I had, than I have from my family. And that's due to the changes in my journey and the people I've met as an adult, both within my professional life and in my personal life. [Meagan].*

> *It's through working, and I've worked in a few different areas in nursing, there's been some of those areas like the value of personal life that I've had to re-think. Some of those and some of those values have been modified a bit through experience that I've had with my nursing, definitely … there's been some big sort of value questions I guess that experiences in nursing have definitely had an impact on…. I've probably changed some of the attitude that I've got from when I before I started nursing … but through nursing experience the exposure to more varieties of life … and some experiences in that specific nursing it's made me realise that maybe some of the ideas that I had, some of the values that I held, maybe they could modify [but] still stay within my Christian belief system … clear cut ideas prior to nursing aren't so clear cut anymore. [Tim].*

Commitment to certain core values or beliefs systems is still maintained. However, when nurses have been exposed to situations that have challenged some of their views, they accept they may have had a limited understanding of particular issues and are prepared to make modifications. This often occurs as a result of being exposed to situations that indicate issues have more complexity to them than they initially were aware, and there are now new perspectives to consider. As a result they modify,

qualify, or surrender particular values or beliefs and might even go so far as to subscribe to a different value or belief.

Further along the continuum, rather than completely abdicating certain values/beliefs, nurses may choose to self-negotiate them. Negotiation involves setting certain values or beliefs aside temporarily, or at least giving them lesser weight, because something else is deemed to demand greater importance at the time. In so doing they give primacy to different values/beliefs than they might otherwise in another circumstance. They choose to do this, and justify its acceptability to themselves, because it is considered necessary to protect client welfare or autonomy which in the particular situation is deemed to have primary importance.

> *I have compromised my personal beliefs in order to provide professional care to a patient…. Normally I would have said no but because of the woman's distress and the doctor's need, I did it. [A response to Vignette 1].*

> *I am prepared to compromise my beliefs on a regular basis if that is in the best interest and the wishes of the patient. My personal beliefs come second to those of the patient. [A response to Vignette 2].*

> *There's values that I won't compromise but they're not values that I would consider affect the nursing practice I have. It's the values that play a part in my nursing practice I feel are values that, they're not transient, but there's a little room to move depending on what's happening. [Tim].*

When personal values/beliefs are self-negotiated the nurse reflects on what needs to be given priority consideration in the situation and re-orders his or her values and beliefs to allow that to occur.

At the other end of the continuum there are personal values/beliefs that nurses choose to maintain. This may be done in order to protect client autonomy where that is a priority and is a value being challenged. Or it may be done where a decision has been made by another person, or others, that is contrary to the nurse's values/beliefs and the nurse is not willing to make any concession.

> *If I felt as strongly as Nurse A regarding termination of pregnancy, I would have responded in the same manner and requested not to be allocated this patient. [A response to Vignette 1].*

> *I was going inside all this turmoil because I knew legally what I had to do, I knew the pressure on the system to make sure that it was done, but I just*

couldn't do it ethically. I just couldn't do it. So I, this is where the process is coming in I suppose. I went back to the psychiatrist and said 'well look, you want him to have it, you give him the injection, I'm not giving it'. I said 'I'm quite happy to go and check that he's not being sick, or side effects, but I will not give this injection'. [Mikaylah].

We agreed to disagree and I declined my services for this couple. However, I set up for the procedure ... [but] was not present for the procedure. The doctor managed without me. [A response to Vignette 1].

Situations where nurses decide to maintain personal values or beliefs, and this puts them at odds with how others would normally expect them to act in the situation, can result in conscientious objection. Conscientious objection occurs as a result of a nurse reasoning through a situation and making a determination that he or she wishes to hold on to strongly held values or beliefs that are involved and so refuses to carry out duties requested or required (Johnstone, 2004). In such circumstances a stand is taken to maintain carefully considered personal values/beliefs even though there may be risks associated with such action.

Where nurses would place themselves on the continuum at a particular point in time depends on the ethical situation being faced, and the values/beliefs being challenged. Some nurses, as a result of previous experiences, may change the weighting they would give to particular values/beliefs. Similar experiences may have resulted in outcomes that have made them re-assess the order in which they place certain values or beliefs, resulting in a shift on the continuum. However, if actual core values/beliefs are being challenged the nurse may hold strongly to them and not be prepared to abdicate them.

I think if you treat everyone fairly and equally and justly I don't think you can compromise that…. Yes I think we all tell white lies at times but I think the core values you have to follow because once you start compromising then where does it end? [Alisa].

I would be committed to maintaining an ethical framework of practice which includes [a] patient's right to autonomy, informed consent, non-maleficence. I have a responsibility to tell the truth all the time. [Michelle].

These core values and beliefs may vary from individual to individual.

Complications occur when two or more values/beliefs which a nurse considers are core, and to which he or she is committed, come into conflict. In such situations

there is a need to carefully consider the weighting each should receive and therefore the order in which they should be placed.

> *I have been in situations where nurses would not care for patients having abortions because of their belief system. In these situations I have taken the patients and cared for them. I don't totally agree with abortions but it really is not my decision to make. [A response to Vignette 2].*

So even though particular values or beliefs are strongly held they may be given secondary importance in situations where it is accepted that the client's autonomous decision and need for care should be given higher weighting. Nurses who choose to do this defend their decision by justifying respect for client autonomy must take precedence.

Maturing as a person also influences nurses' personal values/beliefs and how they might be weighted. In turn, this has an effect on where they would place themselves on the continuum when deciding whether certain values can be abdicated, re-ordered, or maintained.

> *I think the older I get, more and more I realise that life is grey and not black and white. You know when I was 21 it was very black and white. It's not black and white anymore, it's very grey. [Meagan].*

> *I'm certainly not the person I was 30 years ago, 20 years ago. I don't think I am ... as I've got older I think I've got more compassionate. I think I've always been caring. And then I think that the revelation that the patient's really in charge has evolved. [Belinda].*

Modifications to values and beliefs, including the weighting they may be given, as a result of experiences and maturity can result in nurses finding it difficult to remain with moral rationalism. They may find that previously accepted moral obligations fail to give them sufficient guidance in ethical reasoning. Instead they become aware that other elements are also motivators for how they respond in a way that, for them, is ethically justifiable. Data in the current study indicate that respect for the right of a client to make autonomous decisions is one such important element. Similarly, compassion as a component of the caring role of nurses is a key factor often requiring consideration.

It is acknowledged that reliance on ethical obligation is not necessarily excluded when a nurse modifies his or her values or beliefs so that more focus is

given to other elements such as client autonomy or compassion. The possibility exists that these elements may then be recognised by the nurse as important but are simply taken on as professional moral obligations. However, that is not the only option. Through experience and maturity the nurse may have reasoned through and reflected on ethical issues encountered such that there is increased appreciation of the complex nature of moral challenges and the various components requiring consideration. This realisation encourages an evaluation of personal values and beliefs and the importance of them in the professional environment. As a result, there can be comfortable acceptance that some level of flexibility, as opposed to moral rigidity, is allowed when responding to personally challenging situations. However, the existence of core values/beliefs is also recognised, with an associated acknowledgement that they take precedence and are unlikely to be compromised.

Using the context of a religious person weighing up the merit of a theory, Wolterstorff (1984) suggests that individuals have different types of beliefs to which they refer, particularly if inconsistencies exist. I believe this can also be applied to determining one's commitment to certain values/beliefs when reasoning through ethically challenging situations where core versus other values/beliefs are involved. Wolterstorff (1984) points out that the three types of beliefs to which he refers, "*data beliefs, data-background beliefs*, and *control beliefs*" (p. 69 emphasis in the original), differentiate in how they function rather than identifying the essence of the belief. The data-background beliefs held, and there will be a large set of these, will determine what data is accepted or rejected when weighing up a theory. When used to weigh a given theory, these data-background beliefs are considered to not have problems and are themselves not weighed. The control beliefs are those that are used to determine which theories will be rejected because they are not consistent with those beliefs. In applying this to a religious person, Wolterstorff (1984) contends that it is religious beliefs that "ought to function as *control* beliefs" (p. 70 emphasis in the original). These control beliefs therefore stem from an individual's worldview and are strongly held. Nurses' control beliefs are the core values and beliefs they hold which they are not prepared to compromise. These core values and beliefs are used to weigh up any new data and to make decisions. The remaining values and beliefs, which are

not considered as core, are data beliefs, and may be weighed differently in various circumstances, or on occasions even abdicated.

Integrating or separating values and beliefs

Integrating or separating values and beliefs refers to nurses deciding whether specific personal values/beliefs ought to be considered as being relevant to the workplace, and if relevant, what weighting they ought to be given. Data in this study identified two opposing stances in relation to this. Some participants indicated they integrate their personal values/beliefs into their professional role, whereas others indicate a need to keep them separate.

Nurses who argue they integrate personal values and beliefs into their professional role reason that individuals' values/beliefs are a fundamental part of who they are. As such, they consider it is impossible to have two sets of values, one for work and another for their personal life.

> *My personal experience and philosophy is that you can't divorce them. You bring to any situation who you are as an individual in your entirety. And if that's super-sensitive, compassionate, loyalty, all those qualities, as well as the undesirable qualities of perhaps some aggressiveness or any of the other qualities, you can't really separate yourself from your personal and private life. [Nathan].*

> *Every nurse brings their own personality into nursing... the values that I hold have impacted on the way I've done my work definitely, but there's no question that my values determine the type of work that I do ... you are fooling yourself a bit if you think you can have two separate lives.... I mean you've got to separate work and home, definitely, but your under-riding value system has to flow through, it has to be consistent in both. You can't have one set of ethics at home or one set of values at home and then turn around and have totally different set somewhere else ... to me I just can't see how you could do that because values are more than just action. [Tim].*

When nurses identify that they incorporate personal values/beliefs into their work setting they are making a conscious decision to reject playing different roles in different settings. To do otherwise they see as untenable and contrary to their personal integrity. They acknowledge they are holistic and integrated individuals and that all of the dimensions which make them human form their total being. To separate any one part from the rest is not accepted as possible. For these nurses, personal values/beliefs function in the professional arena and can influence the clinical

decision-making process and subsequent actions. However, they still give careful consideration to protecting client autonomy and will take measures to ensure that they do not impose their own values/beliefs on clients. This occurs because the value of respecting client autonomy is considered primary.

However, a different kind of reasoning is evident by nurses who argue they deliberately separate their personal values/beliefs when in the professional environment.

> *I have a religious philosophical belief system but I separate that from my work practice, and I do practice my nursing from a humanitarian aspect so I don't really let that interfere. [Michelle].*

> *Whilst I have a fairly strong personal view on the sanctity of life, those are my views and this was not the time or the place for having those views interfere with my professional conduct on a day-to-day basis.... So yes, my own personal value, morals are such that they believe in the sanctity of life and the importance of guarding life ... but I won't let that compromise a clinical situation. [Cameron].*

Nurses who take this stance intentionally identify for themselves which values and beliefs they consider to be personal, in order that they can be separated from their professional functions and decision-making processes. The objective for this, in part, is to ensure they do not impose their own values and beliefs onto the client and this is aided by maintaining an awareness of their personal views and keeping them from influencing their professional roles.

Additionally, consciously separating what they consider to be their personal opinion about an issue from their expected professional duties is used by some nurses as a strategy to help them cope with ethically challenging situations.

> *I'd say there are times I have to separate. Like when I'm looking after this child that's been withdrawn all food because, well the family can't cope with this child being a vegetable. I have to separate my belief system to be able to work. [Jade].*

These nurses have found this strategy helps them deal with situations in the work environment which would otherwise cause them ethical discomfort. By accepting there are personal components to their being that do not have to necessarily play a part in their ability to carry out their professional roles, they are able to ethically

justify being involved in activities which they would not necessarily choose for themselves. This form of reasoning gives them a way of separating themselves from an ethical decision that has been made and with which they do not agree. Accepting they are not part of the decision itself allows them to comfortably justify their involvement in the ramifications of the decision. This then allows them to separate their personal values/beliefs from the situation and is used as a means of coping with issues that personally challenge them.

> *Well do you find at times you separate your private person from your professional decision-making? [Researcher].*
> *Definitely. That's how I survive…. I've always been raised with that certain things are a mortal sin and should never occur. And so therefore very often I have to take, if I'm starting to feel uncomfortable, I have to look at that and I think that's where it's coming from. [Lauren].*

When nurses undertake separation of their values/beliefs in these situations they are recognising that clients are entitled to make choices for themselves. However, if clients choose options that are not compatible with the nurse, the nurse copes with the situation by accepting personal values and beliefs need to be separated from the professional situation.

Although nurses who are reconciled to this stance say it allows them to cope with ethical situations that are personally challenging, there is no guarantee the process will relieve them of moral ambiguity. Koerner (1996) contends that:

> when we compromise our dreams and our values for someone else's, we give away our power. The more we sacrifice our authenticity, the more disempowered and disabled we become. Living outside our value system is exhausting; it takes much energy because our inner selves are not congruent with one another. (p. 77)

A degree of ethical comfort may occur because these nurses believe that not imposing their own reasoned choices on clients is the right thing to do. But when it results in the nurses having to be involved in actions which are at odds with personal values and beliefs it can still cause moral tension.

While two stances, integrating or separating personal values/beliefs, were identified in the current study, it is apparent from the data they are both, to some

extent, carried out with a similar objective – that of respecting client autonomy. Nurses who reason it is appropriate to integrate personal values/beliefs into their professional activities do so because they believe that as holistic beings they are a fundamental part of who they are, irrespective of the setting. Further, they recognise these values/beliefs influence how they perform their professional role. A priority value/belief for them is client autonomy and therefore integrating this into their professional role is important. Nurses who argue it is appropriate to separate personal values/beliefs from their professional activities are making reference to the importance they place on ensuring they do not impose their personal opinions or decisions on to their clients. To make sure this happens, they separate their personal values/beliefs from their professional roles, rather than imposing them on to clients.

Separating personal values/beliefs from those of clients can also be a mechanism used by some nurses to help them cope with situations where clients make choices that cause the nurses moral discomfort. They accept that they cannot impose their own choices on clients and so consciously separate them out of the situation. This gives them a level of moral comfort because they are able to defend the outcome as being acceptable, given their moral duty is to allow client self-determination.

Other research related to dealing with challenges to personal values/beliefs

The current study found that nurses' involvement in ethical decision-making, and their associated power to protect client autonomy, is circumstantial. In some settings, nurses' views and opinions are listened to and considered, whereas in others they are either not sought or dismissed. That there are times when nurses experience limited opportunity to assist in dealing with ethical challenges and decision-making supports findings by other researchers. An Australian study of neonatal nurses reported that 21 per cent of participants indicated "they were never involved in ethical decision making" (Spence, 1998). Even nurses who are highly experienced find they sometimes receive little support to be involved in resolving ethical dilemmas (Penticuff & Walden, 2000). Doane, Pauly, Brown and McPherson (2004), in a study of Canadian nurses, reported their participants often found they were powerless to

deal with ethical challenges. The nurses found this situation particularly difficult, "bearing the responsibility of the day to day care of patients yet having no role authority to ensure that the patients received ethical care" (Doane et al., 2004, p. 247). Similarly, a study in the USA found that involvement by the participating nurses in deliberations about ethical issues was limited (Corley et al., 2005). The authors suggested this could impact on the nurses' moral distress levels in a major way and should therefore be addressed as a means to help reduce moral distress. Oberle and Hughes (2001) reported that nurses in their Canadian study indicated that they were not listened to and did not have opportunity to impact decisions related to end-of-life issues, even though they had in-depth knowledge and understanding of clients. In contrast, the majority of participants in a study of Finnish nurses indicated their views were sought in relation to 'do not resuscitate' orders for patients, although not all of them believed they were listened to with only half feeling they had some level of impact on the decision (Hilden, Louhiala, Honkasalo, & Palo, 2004). When nurses are not involved in ethical decision-making themselves, their ability to determine if clients' autonomy is being protected, and to advocate for clients if necessary, can be seriously thwarted.

Findings in the current study support Seifert's (2002) suggestion that nurses have both personal and professional dimensions which, at times, may be in conflict. In situations where personal and professional values come into conflict, she encourages nurses to remember that their primary duty is to clients. The right of nurses to refuse to participate in situations which do not reconcile with their values/beliefs is acknowledged, but "only when that decision has been communicated appropriately and other arrangements have been made to ensure that the patient receives the necessary care" (Seifert, 2002, p. 310). Additionally, nurses are cautioned by Seifert (2002) against using undue influence to change the opinions of clients when they differ to those of the nurse.

The finding in the current study that some nurses separate their personal values/beliefs from the professional setting, whereas others do not, concurs with the work of Doane et al. (2004). In their study of student and registered nurses in Canada, the participants identified "a process of reconciling what they termed their personal

self with their professional self" (Doane et al., 2004, p. 243). They found nurses involved in direct client care reported uncertainty, and at times confusion, about the extent they should involve their personal selves in professional ethical decision-making. Some argued it was impossible to separate personal values from ethical decision-making but expressed uncertainty as to how to appropriately integrate them into the profession situations. However, others were concerned that if they referred to their own values in ethical decision-making they risked imposing them on their clients. This uncertainty and confusion was in contrast to the student nurse group who, in general, found relief from tension between the self and the profession by a process of continual reconciliation between the two. Accepting it was an evolving process requiring that they remain true to themselves by trusting the judgements they made was considered important. Similarly a third group in the study, registered nurses in advanced practice positions, found it was necessary to reconcile the personal and professional selves "to be effective in their roles and true to themselves as moral agents" (Doane et al., 2004, p. 245). This reconciliation process was emphasised by these advanced practice nurses as important in order for them to maintain their moral identity.

Summary

In Chapter Six I have given detailed descriptions of the second category - **determining duties to other/s versus self** - in the process used by nurses to deal with personal challenges to their personal value and belief systems. In the first phase, **positioning self as decision-maker**, a nurse will work through a process of deciding whose choices should dominate in relation to the ethical situation at hand. Because of the priority given to the value of respecting client autonomy, in situations where there are competing autonomies, nurses will generally give priority to clients' decisions. Adding to the ethical complexity of some situations, there are times when their power to protect autonomy is limited. Nevertheless, it remains a priority, and nurses willingly accept they should not impose their own values and beliefs on clients. The exception to this is when there are core values or beliefs which they are unwilling to compromise are being threatened, in which case they may choose to conscientiously object.

When **positioning self as moral agent**, the nurse determines what his or her responsibility is to self in the ethical situation. It is apparent one's commitment to values and beliefs can vary along a continuum involving abdication, self-negotiation, and assertion of personal values and beliefs. Where a nurse chooses to be positioned on the continuum at a particular point in time depends on the circumstances of the challenging situation and which values and/or beliefs are involved. The place personal values and beliefs play in a nurse's professional role also require reflection. There are differing opinions as to whether personal values and beliefs should be integrated into nurses' professional decision-making, or whether they should be kept separate. Some nurses argue they do the former, indicating it is not possible to separate them out of the work situation because they are part of who they are as a person. However, others argue they are able to keep the 'personal' and the 'professional' separate and that such a stance is an important strategy when dealing with ethical challenges in the work environment. The reasoning and decision-making linked to each of the phases in this second category are strongly influenced by their commitment to protecting client self-determinism when nurses highly value autonomy.

In Chapter Seven I describe the third category in the process used by nurses when they encounter situations that challenge their personal value and belief systems. This is the category of engaging self as protector.

Chapter 7

Engaging Self as Protector in Ethically Challenging Situations

So we came out of the room and I said 'you know B [the doctor] this is x [sic] amount of times we've spoken about this. This woman wants to go home and this is too much'. And he said 'oh no, I'll know, we'll know when it's enough'. And I said 'I think we've hit enough now you know. She's said repeatedly that she's had enough of this'. And we had quite a heated discussion about what would I know and what would he know.... But in the end we decided yes it was her decision and what he was planning to do was probably not going to do much in the long run.... Really hard going in fact, just in terms of making sure that her needs got met. [Rachel].

The role of protector is one which nurses who value client autonomy take seriously and in which the regularly engage. Although actually protecting another's autonomy may sound antithetical, nurses who give it primacy recognise the autonomy of health care clients can be very precarious. It is at risk of being compromised, or even lost, at any moment by any number of situations, including the person's physical condition, the effect of drugs or other therapies, or the lack of knowledge. By engaging themselves as protectors, these nurses want to ensure their health care clients are respected as autonomous human beings whose rights are protected and whose needs are identified and catered to.

Chapter overview

In this chapter I describe the third category - **engaging self as protector** – which emerged in the substantive theory. This category identifies what it is nurses actually do to protect client autonomy. Two different sub-processes are apparent when nurses choose to take on this role: (1) **yielding to constraints** and (2) **risking self**. These will each be described in turn.

Category 3: Engaging self as protector

Nurses, as moral agents, believe they play a major role in protecting client autonomy. They accept this as an important ethical function because they are caring for people, many of whom are in vulnerable situations. Health care clients, particularly those who are experiencing illness, are potentially vulnerable because

when accessing care they are usually required to be in unfamiliar settings, interacting with strangers who may have to carry out personally invasive procedures on them. Additionally they have to take in new and at times complex information about their condition and treatment requiring them to have to make decisions. This matters to nurses because they care about their clients and want to ensure they are protected from situations which risk erosion of basic human rights and dignity.

> *Well you're dealing with humans, not numbers, not machines, so it's just your daily life you make ethical decisions. [Michelle].*

> *What we're doing is being involved in people's lives at such an intimate point. We are seeing people stripped bare most of the time…. So we have an ethical responsibility to realise that, so that we treat them ethically and responsibly. [Belinda].*

Nurses who engage themselves as protectors generally do so as part of their advocacy role.

> *They're [nurses] very much a patient's advocate and I think also to ensure that the patients have been given all their right choices as number one. [Lauren].*

> *Nurses are the advocates … we keep the balance … we're in a perfect position to keep ethical issues at [a] reasonable level so that things don't, I mean some people have a lot of power, nurses are stuck in the middle, but patients [are] down here with little power at times…. We've got to preserve patients' rights and make sure that nothing, you know everything goes well for them. [Angela].*

They accept that health care clients can at times be in vulnerable or powerless situations. By taking on the role of protector, nurses do what they can, in the given situation, to empower the client to be autonomous.

Although data in the current study overwhelmingly indicated nurses usually choose to actively engage in the process of protecting client autonomy, it is acknowledged they may opt not to do so in some situations. Such decisions result from a variety of factors, including a failure to recognise the pertinent ethical concerns, a feeling of powerlessness to make any difference if action were taken, or a belief the potential risks to self or others are too great.

> *And I was sitting back and listening to all this dialogue and my natural instinct for support the underdog rose up. And I knew I didn't have the forum to speak so I didn't speak because I knew if I'd said that, you know, poor him*

... he's a victim.... I knew if I'd spoken up at the point prrrr [sic] daggers and guns. And so I kept my silence. [Holly].

I hate too how they stand outside of the room at the nurses station and you've got a patient dying in a room that's just opposite and you've got them sitting out there chatting about how long that patient's going to live for. And the doctor's like 'oh well, I've already written four death certificates today, here comes another one.' And the family are like from me to probably not even that wall away in the room sitting with their loved one that's dying. And I did, and actually yesterday, and I didn't turn around and say 'that family', I was like 'that family's in there', I was sort of this far from saying it. But you know that if you say it you get looked at as if to say, well so? ... that's something to me I saw that I didn't like but it wasn't ethically threatening to the patient, so I sort of thought, and it was ethically damaging to the family if they heard. But you sort of look at it and you think if you say something.... I still feel at the bottom of the rung because I am so new and we do get treated like we're stupid sometimes. [Carlee].

In this example Carlee has acknowledged the potential for ethical damage to occur. Nevertheless, she chose not to speak out about it, justifying her decision by indicating other staff would consider it an inappropriate act and she did not want to risk ridicule. However, the example also illustrates that when dealing with challenging situations nurses need to be able to distinguish between ethical concerns and other types of problems, along with the reasoning processes required. The doctor's actions were an example of ethically questionable behaviour irrespective of whether or not the family overheard. Along with that was the potential for psychological damage to occur if the family had heard.

Unfortunately, when nurses fail to correctly identify the issues involved in a situation, and the way multiple concerns may intersect, there is the potential for them to fail to engage as protectors. This can, in some situations, risk the safety or welfare of clients. Similarly, if nurses choose not to act because they believe they are powerless to make a difference, or they are concerned about the consequences to self, clients can be exposed to increased vulnerability.

When nurses make a choice to engage themselves as protectors of client autonomy, there are two major ways this occurs: (1) yielding to constraints and (2) risking self. If they decide to yield to constraints, they choose to yield what they normally would want to happen in the situation, in order to protect client autonomy

where that is required. Additionally, they may also at times yield up their own choices because legal or institutional requirements prevent them from following through with what they would personally opt to do. When nurses engage themselves as protectors by choosing to risk themselves, they are prepared to put their reputation, credibility, or even their employment, on the line in order to ensure client autonomy is given priority.

The coloured sections in Figure 7.1 below illustrate how the category of 'Engaging self as protector' and its phases link together and relate to protecting client autonomy, and where they fit into the substantive theory.
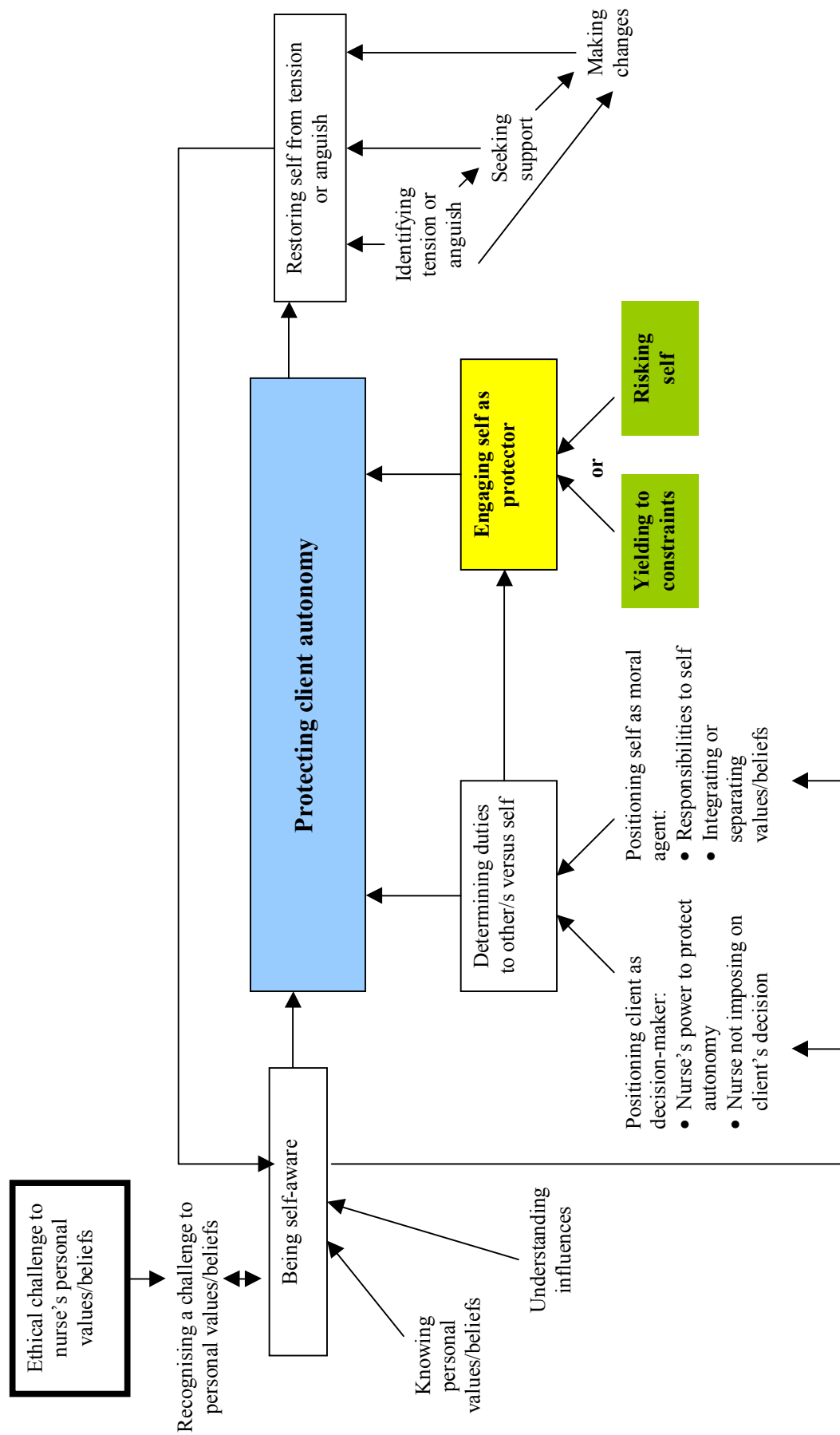
Figure 7.1: Category 3 – 'Engaging self as protector' and its place in the theory

Yielding to constraints

Nurses will, at times, choose to yield to constraints when protecting the autonomy of clients. The word 'yield' is generally associated with giving up or surrendering, often to some higher authority. One of the several definitions provided in the *Macquarie Dictionary* is "to give up or over, relinquish or resign" (Delbridge & Bernard, 1998), and this is what is being referred to when the word is used in the context of this substantive theory. Constraint means "confinement or restriction" (Delbridge & Bernard, 1998). In the context of this theory, constraint refers to something, or someone, that restricts the nurse's ability to act as they would choose to in a situation, or curtails client autonomy. Therefore, when nurses yield to constraints, they accept there are factors at play which prevent them from carrying out their own reasoned choices and/or allowing the decisions of clients to prevail. Nurses may yield to the constraints of legal implications, orders from those in authority, institutional policies, or resource limitations that prevent them from following through with the decisions which they, or their clients, make. Additionally, nurses may be prepared to follow decisions, which are contrary to their own, made by others. They choose this path because they perceive failure to do so could erode client autonomy or cause harm to others such as clients, clients' significant others, work colleagues, or themselves. The harm could be in any dimension of a person's being.

When nurses yield to constraints, generally they not giving up the actual values/beliefs on which their decisions are based. Rather, it is their right to follow through and act on personal choice that is relinquished. Yielding to constraints, it is acknowledged, may occasionally result in the abdication of values or beliefs, but more often it involves them being weighted in a way that is different to what the nurse would otherwise prefer. Nevertheless, nurses in these circumstances are prepared to yield to constraints for what they determine to be justifiable reasons. This may not result in an outcome with which the nurse is comfortable or satisfied, and usually occurs in situations where it is accepted the constraints limit other options.

> *The other ethical thing is when the doctor's giving orders that you don't believe are right, if the patient is willing and it's not going to do harm, if you try and convince the doctor and he doesn't listen, if it's not doing harm there's not much point in pursuing it. [Chloe].*

Although nurses may be able to justify to themselves that the constraints imposed on them in a particular situation gave little option other than to relinquish their personal choices, the resulting discomfort from it may be experienced for an extended period of time.

> *He [doctor] says "The family wants everything done. To cover myself, and liability, I want those IV fluids going before she dies". He didn't dispute the fact that she was not long for this world. There was at one time five nurses sticking her. I had to walk out. It almost became objectified and this was an opportunity for everyone to practice their skills at cannulating. And I was horrified. I had nightmares. It still upsets me…. I wanted to physically stop the other nurses from sticking that little old woman and I could not. I knew she would be dead within the hour and I knew that if I stopped them I would be up on charges and lose my registration. And I had to weigh, I had absolutely no power, I either sacrificed opportunity to nurse other patients or I tried to protect her last hour of life. And that was not a pleasant thing at all. [Chloe].*

In the example above, Chloe's response to the situation was to walk away from it. In so doing she yielded to decisions, with which she did not agree, made by her work colleagues. Responding to the situation in this manner indicates she perceived constraints were in place that prevented her from doing what she would have elected to do if other factors were not at play. This would be to stop what she considered was inappropriate treatment of a client. Chloe reasoned, perhaps in error, she could not influence her more senior colleagues to accept what they were doing was unethical. What was happening was dismissive of the client's rights, particularly given she had already lost her autonomy. But to make such accusations, Chloe believed, would have placed her credibility, or even her employment, in jeopardy. By walking away she was able to physically separate herself from the incident and at the time that may have provided a degree of ethical resolution. However, Chloe admits the incident still causes her ongoing distress. Perhaps, on reflection, Chloe now realises there were other options available to her beyond that of yielding to the decisions, made by her colleagues, which resulted in a client being treated as an object rather than a human being. That realisation can add to the ethical burdens experienced in the incident itself.

Yielding to constraints may at times be perceived by nurses to be the only option available to them. This is likely in situations where it is reasoned that to do otherwise will result in illegal activity occurring, or bring undue harm to self or others. However, there are also circumstances where other options, such as risking self, are considered. This requires nurses to be mindful of the likely ramifications of the different ways in which they can engage as protectors and to determine the level of risk they are prepared to take in the situation.

Yielding to legal constraints

As much as nurses may wish to protect client autonomy, where there is a conflict between a client's wishes and the law, priority will normally be given to ensuring illegal activity does not occur. In such situations nurses will yield to the constraints of the law even though their ethical reasoning indicates they consider alternate action as ethically justifiable.

> *But for me the dilemma was poor man, I was his friend, I let him down. I know I had no choice but to ring an ambulance, but I felt bad about that ... personally and ethically I knew that's not what he wanted ... unfortunately legal things take priority. [Emeline].*

> *The only thing that would get me would, and it's not from a religious belief thing, if one was confronted with something that was illegal. [Cameron].*

Having to work within the boundaries of the law can in some situations cause, or compound, the moral tension or anguish with which nurses may have to deal. This is particularly the case if nurses are legally required to take an action that goes against their own personal values/beliefs.

> *Then I have to decide what I'm going to do about it…. I think the one [consideration when deciding] that stands there on top is the legal because there's so many legal issues…. That causes me a lot of angst sometimes…. I was going inside all this turmoil because I knew legally what I had to do. I knew the pressure on the system to make sure that it was done. But I just couldn't do it ethically, I just couldn't do it. [Mikaylah].*

> *The most regular is life support when the prognosis to all intents is zero…. It was against my personal value system, however there was a legal and a professional responsibility to support the client in the environment even though in actual fact I couldn't help but think 'please God may that never happen to me personally or to somebody I loved'. [Nathan].*

Sometimes nurses are overly-cautious in their interpretation of the law, or they misunderstand their legal responsibilities. This can lead to yielding to what they perceive as legal constraints when it is unnecessary. Additionally, nurses may have the view that, within the judicial system, they are given limited recognition for their reliability as a single witness when compared with some other members of the healthcare professions.

> *The patient is of a sound mind prior to lapsing into a coma and has expressed his wishes and nurse Y has carried them into effect. Legally, however, she may have a hard time in court justifying her stance. [A response to Vignette 2].*

> *The thing is the law will stand by their [family] wishes and not by yours, so your ethical practices, although justified when the patient is able to express them are probably not acceptable unless others express the same ie [sic] Dr's or other nurses. [A response to Vignette 2].*

Given the media coverage of litigation linked to health care services, and the difficulties nurses have at times experienced when confronting legal challenges (Forrester & Griffiths, 2005), caution when considering legal responsibilities is understandable. However, being over-cautious in its application can result in clients having some of their rights diminished. Nurses need to make sure they correctly understand their legal responsibilities and adhere to legal requirements if they are to also ensure they practice with moral responsibility.

That nurses have responsibilities in respect to both ethical and legal aspects of nursing care is acknowledged in the *Code of ethics for nurses in Australia* (ANMC, 2002). In explanatory statement 1, value statement 5, it states that "As morally autonomous professionals, nurses are accountable for their clinical decision making and have moral and legal obligations for the provision of safe and competent nursing care" (p. 5). Additionally, in the domain of professional practice in the *National competency standards for the registered nurse* (ANMC, 2005), it states that a competent nurse "Practices in accordance with legislation affecting nursing practice and health care" (p. 2). It is professionally prudent for nurses to ensure that ethical decision-making is conducted within legal boundaries. Nevertheless, it is also essential for nurses to clearly understand the legal implications of situations and to ensure they are not misinterpreting their legal responsibilities.

Yielding to client choice

Given the high priority nurses place on client autonomy, it is not surprising they are sometimes prepared to relinquish their own reasoned choices in order to support the choices clients make. Because they accept the client's self-determined choice should take precedence and it is inappropriate for a nurse to impose his or her values and beliefs into the decision-making process, yielding to what the client has chosen is seen as justifiable. They willingly accept that although the final decision may not accord with their own reasoned choices, these can be moved aside because higher weight is given to client autonomy in the circumstances.

> *A patient with advanced cancer who was bed bound and very debilitated wanted to continue to pursue another opinion about further treatment because they were not ready to die. I facilitated this process even though I believed it to be futile. The patient was young with young family and was not ready to die yet. Even though my experience told me that their time appeared limited, I wanted to support their right to decide for themselves. Even though to me death in surgery would be terrible compared to dying surrounded by family in comfort and dignity. This is what the patient wanted. They needed to know they 'tried everything'. [A response to Vignette 2].*

The dilemma for nurses in situations such as the one in the example above is that they perceive a conflict between what a client chooses and what as health care professionals they consider is realistic. They are forced to determine whether or not they should continue to give precedence to protecting client autonomy when, from their clinical knowledge and expertise, they believe the choice to be inappropriate. Nurses are prepared in such circumstances to give up their own considered opinion and allow the client's decision to prevail when, having reasoned through the issues, they still maintain client autonomy as primary. Such reasoning could suggests a teleological approach to ethical reasoning where the focus in on choosing an option that will give a 'good' outcome rather than determining action based on what one considers is a duty. However, it cannot be discounted there may also be occasions when nurses yield to client choice as a result of deontological reasoning because they determine they have a moral obligation to give precedence to the decisions of clients.

Yielding to the wishes of family (or significant others)

At times, nurses have to give regard to the wishes of a client's family, or significant others, especially in situations where the client is not considered capable of giving legal consent. As much as nurses may want to protect what they believe are

clients' autonomous wishes, there may be decisions made by others that they perceive restrict their ability to do so.

> *It wasn't a dementing process that was ripping it [percutaneous endoscopic gastroscopy (PEG) tube] out. She didn't want it, she'd had enough. But you know it puts you in a really difficult position when you're having to send this person you're caring for back to have this tube inserted at the family's wishes, because the family are insistent that she be fed and hydrated. [Emma].*

In this situation the client had restricted communication ability but because she kept removing her tube Emma, the nurse, believed it was her desire to not have it. However, she yielded to the family's choice that it be maintained until it was finally ceased after the guardianship board intervened. It can be ethically problematic for nurses when they consider they have no option but to follow decisions made by others which are contrary, they believe, to the wishes of the client. Emma judged that in this situation she had no other recourse, at least until legal clarification was obtained.

> *The family decided not to tell her, you know, she in fact had a terminal … cancer…. I thought it was pretty cruel really…. And she kept asking 'what's going on?' and no one was allowed to say anything. And I think that was one of the hardest things in fact, she just needed to know and yet you couldn't say … and that became very difficult for a lot of the nursing staff…. It was sort of heartbreaking in a way because of the kids and the decision they'd made that you know in a way you're obliged to support it. But it was, yeah, it was a worse death than it should have been and it was, and I felt strapped. I couldn't give appropriate nursing care under those circumstances, difficult. [Rachel].*

In the second example above, Rachel reports an incident in which she had to choose between respecting a client's right to be informed about her condition and the request of family members that the client not be informed her condition was terminal. The client was aged in her early 30s with young children (who were also not informed of the terminal nature of the illness), so had the right to make her own informed decisions. It is evident that Rachel found being forced into such a position distressing. Although she chose to yield to the wishes of the family, she did not find that ethically comfortable. Along with other nursing colleagues, she questioned the appropriateness of such a decision but in the end concluded they had an obligation to give higher value to the family's wish to keep a secret, although her reason for this was not forthcoming.

It is possible that in some circumstances nurses perceive they have a duty to act in a particular way and this would suggest a deontological approach to ethical reasoning. However, it is also possible that a teleological approach to ethical decision-making is used by some nurses in such circumstances because they deliberate on the likely outcomes of the various options available to them and choose the one they consider will have the 'best' consequences for the parties involved. This example also illustrates the moral burdens carried by nurses when they believe they have to go along with ethical decisions made by others, especially when the ethics are highly questionable.

Yielding to authority

Nurses will at times yield their own reasoned choices to follow decisions or orders from those in authority. Nursing colleagues with more seniority, doctors, management, or institutional policies are examples of such authority. The possibilities of disciplinary action or negative consequences to their employment are factors which often motivate nurses to yield to what they perceive to be powerful individuals or institutions in these circumstances.

> *I'm not talking anymore, I just keep quiet now. There you go. You can see now that bureaucracy and the authority, the power there. You might as well shut up, otherwise you pay the penalty. [Yasmin].*

> *I was following orders because I know that if I had not done so, I would face disciplinary action from management. [A response to Vignette 1].*

In these examples, the participant data illustrate that nurses can face situations which require them to decide if their actions can reflect their own values and beliefs, or whether they will set those aside and follow different orders or protocols given by those in authority. Nurses may consider the outcomes of the actions they choose in such circumstances and such a process suggests a teleological approach to ethical decision-making. This form of reasoning is apparent in the two examples above from the participant data. However, the possibility that some nurses choose to yield to authority because they use a deontological approach to decision-making, reasoning they have an obligation to follow orders given by those in authority, cannot be discounted.

Mallik (1997a) points out there can be dire consequences for nurses at times when they advocate for clients, stating that:

> Besides the emotional, psychological and environmental constraints placed on the individual, institutional power can still deliver the ultimate punishment, loss of employment. Decisions to advocate can not be taken lightly and in the face of all the barriers, it remains an individual moral choice for the nurse. (p. 136)

If the outcome of not yielding to authority results in something as serious as loss of employment it is understandable that nurses will at times be prepared to acquiesce to the higher authority. However, the reason behind the choice does not remove the ethical component of the decision made. To simply accept one must follow orders given by those in authority fails to acknowledge nurses as "morally autonomous professionals" (ANMC, 2002, p. 5).

Yielding to prevent possible harm to others or self

Nurses may choose to yield in order to protect others from harm. For example, when looking at the larger picture, they may reason that putting aside what they believe should happen in a particular situation will result in less harm.

> *One such situation was on a remote Aboriginal community and one of the leaders wanted antibiotics for a condition that in my opinion, didn't warrant antibiotics. The man was very aggressively demanding his preferred treatment. I rang the flying doctor and asked his advice. His advice was to give them as it would be too dangerous (politically and personally) not to give them and antibiotics had been given previously. I gave the antibiotics. [A response to Vignette 2].*

In the example above, the nurse compromised her clinical judgement and, along with the doctor, chose the least damaging option in the immediate situation. Choosing to yield one's own decisions may also occur in situations where nurses are dealing with clients who are acting aggressively.

> *I think that forced treatment and the containment of people like say in a seclusion area or in a locked ward or having to give them medication against their will or restraining somebody because they're doing something dangerous. Situations like that, personal ideas about how you like to treat people. And often if you're under threat yourself you might have to act in a way that doesn't suit your own preferred way of dealing with people. Like you may have to contain someone in a locked ward or something and lock the door behind them. [Austin].*

The value of protecting self and others is considered acceptable justification, in these instances. When reasoning through the issues in such circumstances nurses determine they need to yield, or give up, their desire to protect people's right to freedom because the protection of self and others is given higher weighting.

Nurses choose to yield to constraints for a variety of reasons. There is evidence in the study data that yielding to constraints is sometimes the chosen option because nurses think it will result in the most appropriate outcome for themselves and/or their clients. This is indicative of a teleological reasoning process where the consequence of an action, not the action itself, is the factor used to determine whether one is making a decision considered to be 'good' or 'right' (Johnstone, 2004; Thompson et al., 2006). However, there is also evidence that at times nurses will determine they have certain obligations from which they should not move, indicating a focus on their duty or the act itself. This is indicative of a deontological approach to reasoning when determining how they will engage themselves as protectors of client autonomy.

Yielding to constraints may in some circumstances assist in providing nurses with moral comfort, particularly if they are satisfied that the 'best' outcome has been achieved for the parties involved. On the other hand, moral comfort cannot be assured and in some situations this adds to the ethical difficulties nurses have to deal with. This will be discussed further in Chapter Eight.

Risking self

Having considered the options available to them, rather than yielding to constraints nurses will on occasion decide on action that could put them at risk.

> *But again nurses are nurses because they care. And nurses have a gut instinct, that's what drives us to it. And if we trust it, if we don't let it be brow-beat out of us by protocols and cranky surgeons, and we trust it and we listen to our patients, then you put yourself on the line. [Chloe].*

The term risk is defined in the *Macquarie Dictionary* as "exposure to the chance of injury or loss" (Delbridge & Bernard, 1998). In the context of this substantive theory it refers to the nurse exposing him/herself to the possibility of injury to professional reputation or credibility, criticism, or in extreme cases the loss of employment. In

situations where nurses choose to take a risk they often treat the client's decisions or needs as paramount and are prepared to put themselves on the line for them. Within the current study data, instances of nurses taking risks were not as frequent as instances of yielding to constraints, nevertheless, examples were present.

Risking reputation or credibility

Nurses at times choose to act in a way that risks their reputation or credibility, particularly in the eyes of their work colleagues. For example, they may refuse to carry out orders because they believe that to do otherwise prevents them from protecting the client's wishes or welfare.

> *And I said 'yes it's [sedation of terminally ill client, showing no signs of distress, at daughter's request] very wrong, we can't do this. This is just terrible'. And the VMO [Visiting Medical Officer] at the time got very angry. It was really terrible…. The daughter was very angry, she never adjusted to it, she could, she couldn't see why we shouldn't do it…. So it was terrible, and the registrar was terribly conflicted and it was a very, very awkward time because this doctor knew that the nurses were very critical of her decision. It's a very tough stance to take, to say to the doctor 'no nurses here will carry out your order'. [Alisa].*

The client in the example above had not been consulted about the proposed treatment and the nursing staff believed her autonomy was being completely thwarted.

> *And I said "Oh well, I don't really think we can do that. I mean this patient's conscious, she's drinking, she's watching television. Have you told her you are going to do this? I mean apart from the fact there's bigger issues than that but has she?" "Oh well no we won't let her know. We'll just, you know, whatever we'll just do it". [Alisa].*

When the nurses in this situation considered the option of following the medical order versus refusing to do so, they chose to give precedence to respect for client autonomy and welfare, so refused to carry out the direction. They accepted there was a risk to their professional reputations in doing so but, in order to protect their client, were prepared to take it.

Similarly nurses may take an action that is not supported by other nurse colleagues because they believe such course of action is necessary for the client to receive appropriate care.

> *And the other nurses are standing there going 'oh my god I can't believe you did that [told consultant by phone she would document she had informed the intern, the registrar, and now him about possibility of client having an acute*

infection likely to go systemic and cause death], what if you're wrong?' And I'm like 'then I've lost all credibility, haven't I'.... I would rather lose my credibility than lose my patient. So it was a gamble I took without hesitation. [Chloe].

The example above illustrates how ethical reasoning and clinical decision-making often intersect with a need to respond in a way that considers both components. Chloe was very concerned for the welfare of her client and using her clinical expertise determined certain treatment was required. She believed she had an ethical responsibility to ensure her client received "safe and competent nursing care" (ANMC, 2002, p. 5). However, her attempts to have the client treated in accordance with her clinical judgement were unsuccessful until she acted in a way that was perceived by her nursing colleagues to be both unprofessional and unethical, with a likely outcome of censure. She was required to choose whether or not she was prepared to take personal risk in order to carry out her ethical and clinical responsibilities for the client, as she perceived them. The precedence given to client welfare and safety over and above any risk to her professional credibility is evident and Chloe made that call even though she was aware of the possible ramifications.

Risking being criticised

At times nurses choose to take action even though they are not supported by work colleagues. This can be particularly distressing when they find themselves criticised for acting in ethically responsible ways.

> *But the staff who were in charge were virtually accusing me of lying because I hadn't given him this Midazolam [sedating medication], as it was his request, and they were more or less insisting that I give it to him on a regular basis. Whereas I felt he didn't really need that Midazolam, he needed more personal attention from the nursing staff.... I challenged the doctor personally, and the nursing staff weren't impressed, and he wasn't impressed. At the time I felt that my patient was suffering and I was thinking of little else ... they [nurse colleagues] didn't support me at all. [Michelle].*

> *I had a patient one time who didn't want to wear the TED stockings [anti-embolism stockings] and she didn't want to wear them home. And so when this woman was getting into the lift one of the other nurses says 'Where's your TED stockings?' I said 'well she doesn't want to wear them so she'll put them on when she gets home she's told me'. I mean that's that person's responsibility, I cannot make that person put the TED stockings on. And they were quite disgusted, another nurse, was quite disgusted with me that I hadn't forced the issue. [Amanda].*

Nurses may also be prepared to question doctors' orders if they believe that the interests of their clients are being jeopardised. This is illustrated in the participant's response given at the introduction to this chapter. Often such action is difficult for nurses, but they are prepared to risk the possibility of reproach because of the priority they give to client autonomy. Similarly nurses may refuse to carry out the orders of a doctor or more senior nurse because they believe the client's welfare could be jeopardised if the order were to be followed.

> *And at the end of the day the supervisor come back and was quite annoyed that this restraint had been removed, and my thought process was, and I can remember saying to her "I can justify in a court of law why an elderly man with Alzheimers disease and arthritis on his hip has fallen under my care and fractured his femur or hit his head, but I don't think I can justify to a Coroners court how I allowed him to choke to death on a restraint, so this is my decision". And I think at the end of the day you have to sit down and sometimes take the good, the lesser of the two evils. [Emma].*

This incident illustrates there can be multiple risks that need to be balanced against each other in some situations. It also illustrates, as do many of the other examples given, the way in which nurses are often required to use both clinical and ethical reasoning simultaneously to justify a decision others may choose to challenge. Emma identified there was a risk to the client if she followed the supervisor's order and applied the restraint. However, if she followed through with her decision not to apply the restraint for the sake of client safety, Emma herself faced a risk, that of the supervisor's disapproval. The ramifications of that could place risk on Emma's clinical confidence. Additionally there were legal risks to consider if the client slipped and choked to death on the restraint (there had been a previous incident where Emma had found he had slipped in the chair and the restraint, although correctly applied, was caught around his neck restricting his breathing). It was an incident that required Emma to reason through each of these possibilities and their implications. In the end, Emma chose to maintain client safety as primary and in so doing was prepared to risk being reprimanded by her supervisor.

There may also be occasions when nurses risk criticism because fellow colleagues misinterpret the motivation behind their actions when their primary focus is the needs of a client.

We had a patient die in the middle of treatment when I was in the emergency and he was cheyne-stoking, and I didn't want to leave him. And I was torn between, he had no family whatsoever, and I was torn between should this man die alone or should I spend the five minutes here with him. And then I had this over-riding guilt that they're going to think I'm sick because I'm here watching this man die…. But I didn't leave because I just put it back to me and thought I wouldn't want to be alone when I die…. So I didn't leave. I thought I'll just stay there and it only took five minutes and he went. [Carlee].

This example illustrates the way nurses have to balance the needs of clients against their own needs at times. Carlee made a clinical decision that the client was close to death and, out of concern for his care needs at the time, did not want to leave him alone. However, she had to weigh his needs against her need to carry out her professional role in a way that was acceptable to her colleagues. In deciding to remain with the dying client she believed there was a risk of that being jeopardised, nevertheless, she chose to give precedence to the client over herself.

Risking employment

Some nurses are prepared to take risks even in situations where they believe that one of the possible consequences of their actions is the loss of their job. This is particularly the case when nurses choose to blow the whistle on colleagues who they believe are performing their roles inappropriately and are therefore jeopardising client care. Making formal complaints, particularly when they involve someone in a more senior position, has associated risks that could include creating an uncomfortable work environment, through to actual termination of employment.

I actually bring up the issue. I told them [nursing colleagues at a meeting] that "if you experience this sort of thing don't hesitate, because it will just get worse". I took the risk [reported unprofessional behaviour by a more senior nurse], because this is not right. But I can understand why some of you will not take it, of course, because they [administration] say "alright this person is the trouble maker, we are not going to hire her in the future or him in the future". And that's for me a big ask. [Yasmin].

Within Australian culture, 'dobbing in a mate' (as expressed in Australian colloquial terms) generally carries severe negative connotations even though it is in line with the principle of veracity. Often negative motives are imputed to the whistleblower resulting in attention being focused on the person speaking out rather than the issues actually being reported. In such an environment whistleblowing is an example of taking a risk. Nurses will at times be prepared to take such action if they believe the

welfare of others, including clients, is being endangered. McDonald and Ahern (2000) found that nurses who reported misconduct experienced serious reprisals as a consequence, whereas there were few negative consequences for those who stayed silent. The reprisals included demotion, being reprimanded, being referred to a psychiatrist, rejection by their peers, and being pressured to resign. However, it is also acknowledged there are personal costs irrespective of whether nurses whistle blow or remain silent. McDonald (2002) found that 70 per cent of whistleblowers and 64 per cent of non-whistleblowers reported they experienced both physical and emotional problems as a result of being involved in a whistleblowing situation.

Tschudin (1998) postulates that "ethics is about doing what we really believe to be right; these days this often means courageously making a point, going against the flow, attacking wrongdoing" (p. 57). Nurses act courageously when they take a risk. If they believe it is the right thing to do and accept that their actions will help protect clients, especially in respect to their rights, autonomy, welfare and safety, they may decide putting themselves on the line is worth the risk.

Other research related to engaging self as protector in ethically challenging situations

The constraints that nurses believe require them to at times yield up their personal choices, identified in the current study, are consistent with, and lend support to, observations made by other researchers. For example, in a study of nurses in the USA who had experienced moral distress, Wilkinson's (1987) participants identified that external constraints to their ability to act in a way they perceived to be moral included "physicians, the law and/or lawsuits, nursing administration, and hospital administration and policies" (p. 21). In addition, they identified internal constraints, which included "nurses' being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage" (Wilkinson, 1987, p. 21). A study of nurses' ethical decision-making by Sherblom et al. (1993) also identified professional and institutional constraints which prevent nurses acting as "morally autonomous professionals" (ANMC, 2002, p. 5). The subjects in their study identified that in relation to ethical concerns, "in their role as nurses they are constrained by

their professional role and relationship to physicians and patients" (Sherblom et al., 1993, p. 456).

The current study also adds to the findings by Zuzelo (2007) that nurses at times yield to authority in situations they believe are ethically problematic. Nurses in Zuzelo's study sometimes felt pressured to follow physicians' orders even though they believed other options may be more appropriate. As such, they had to yield their own belief as to what should happen to follow the orders of doctors. A hierarchical structure, with nurses perceiving doctors as authority figures, sometimes left them feeling powerless to do otherwise. That nurses are sometimes prepared to take risks to help protect their clients also concurs with Zuzelo's (2007) findings that nurses are prepared to put themselves on the line. In fact, on some occasions nurses will confront doctors and offer conflicting opinions even though they risk "lateral violence" (Zuzelo, 2007, p. 354) in response.

The current findings also add to observations by Snowball (1996) who reported nurses had to sometimes take risks in order to advocate for clients' rights and wishes. The risks were often associated with power relations within the health care team. Because of their belief in their ability to contribute to client care the nurses were prepared take such risks and to work through the challenges in an attempt to bring beneficial outcomes to nursing and their clients.

Summary

In Chapter Seven I have given a detailed description of the third category in the process used by nurses to deal with personal challenges to their personal value and belief systems. When **engaging self as protector**, nurses choose one of two major courses of action. Because of the priority they give to client autonomy there will be times when they yield to constraints in order to protect client self-determinism, or because failure to do so could result in illegal activity or bring harm to clients or others. The second option, risking self, occurs in situations where nurses choose a course of action that could potentially place their reputation, credibility, or employment at risk, or result in criticism being directed at them. Nevertheless, there

are times when they willingly elect to do this because of the prominence they give to protecting client autonomy.

The decisions nurses have to make in relation to the course of action they will take are often compounded because of the way legal, clinical and ethical considerations intersect. There is also a requirement for nurses to balance the needs of their clients against their own. Adding further to this complexity is the fact that nurses sometimes have to act on decisions made by others, but with which they do not agree. This can further compound the moral burden. However, nurses believe they have an advocacy role, part of which involves protecting client autonomy. They are therefore prepared, when required, to yield to constraints or place themselves at risk in order to engage themselves as protectors.

In Chapter Eight I describe the fourth category in the process used by nurses when they encounter situations that challenge their personal values and belief systems. This category - **restoring self from tension or anguish** - involves identification of the existence of such outcomes, seeking support to help deal with them, and making changes that assist the process of restoration.

Chapter 8

Dealing with the Effects of Personal Values/Beliefs Being Challenged

> *You can go home and you can think that through a thousand million times and try to figure out how you could have done it better, what went wrong.... People could really eat themselves up with it and it's an important thing to try and teach nurses actually when they're at their, I mean sure reflecting on your practice is really important, but you have to teach them not to let it eat them up, because it really takes a lot of energy emotionally, undue strain, and whether they come out on the other side better off for it I don't know. [Angela].*

If nurses have chosen to accede to the decisions of clients, or others, they may experience a degree of loss to themselves because they have abdicated or compromised their own values/beliefs. They may also find the outcome of challenging situations is unsatisfactory to them, even if they have chosen to give priority to respecting client autonomy or to maintaining their personal values and belief systems. Dealing with these outcomes appropriately and effectively is important if nurses are going to continue to be effective in their professional roles while also maintaining their personal self-worth and integrity.

Chapter overview

In this chapter I identify how nurses deal with the consequences of having their personal values and belief systems challenged by ethical situations in the work environment. The category that explains this aspect of the process is **restoring self from tension and anguish**. Following a description of the category, the three phases within it: (1) **identifying tension and anguish**, (2) **seeking support**, and (3) **making changes** will each, in turn, be outlined.

Category 4: Restoring self from tension or anguish

Going through the process of being ethically challenged, deciding what to do about it, and then actively engaging in the determined response, generally has personal consequences for nurses. Because such actions often require energy nurses may feel emotionally or physically strained by the situation.

> *That challenged me and exhausted me. But I just thought this is what nurses have to do, you know advocate. [Mikaylah].*

As previously identified, nurses will frequently give primacy to protecting client autonomy when personally challenged by ethical problems. The effects and outcomes of this course of action can have negative consequences, requiring nurses to deal with any resultant tension and anguish. Failure to do so can have a serious effect on them personally as well as on their ability to perform their role as carers and client advocates in the future.

> *I'm a person who tolerate[s] behaviour … even if it is not acceptable, for too long. And then when I am sort of not able to, just like a ball going to explode, boom, it has to be filled. And I'm sort of burned out I think because of that. And that's my big frustration. [Yasmin].*

Tension, in the context of this substantive theory, exists when there is ethical discomfort. It is a feeling of anxiety about a situation that occurs because an individual is dissatisfied with the outcome or feels anxious because values/beliefs important to them have had to be given lower weighting than they would have preferred. Anguish, in this substantive theory, refers to a more acute and stronger emotional reaction than would occur with tension. It describes situations where the individual believes they need to remove themselves from the ethically challenging encounter, at least temporarily, because they are so troubled by it. When nurses are disturbed by clinical situations, or their own ethical responses, they seek to establish some degree of equilibrium. The process is one of 'Restoring self from tension or anguish' and requires that: (1) tension or anguish are identified; (2) support is sought; and (3) changes are made.

The coloured sections in Figure 8.1 below illustrate where this category fits into the substantive theory and how each of the three phases link. The link back to the first category of being self-aware is likewise illustrated.
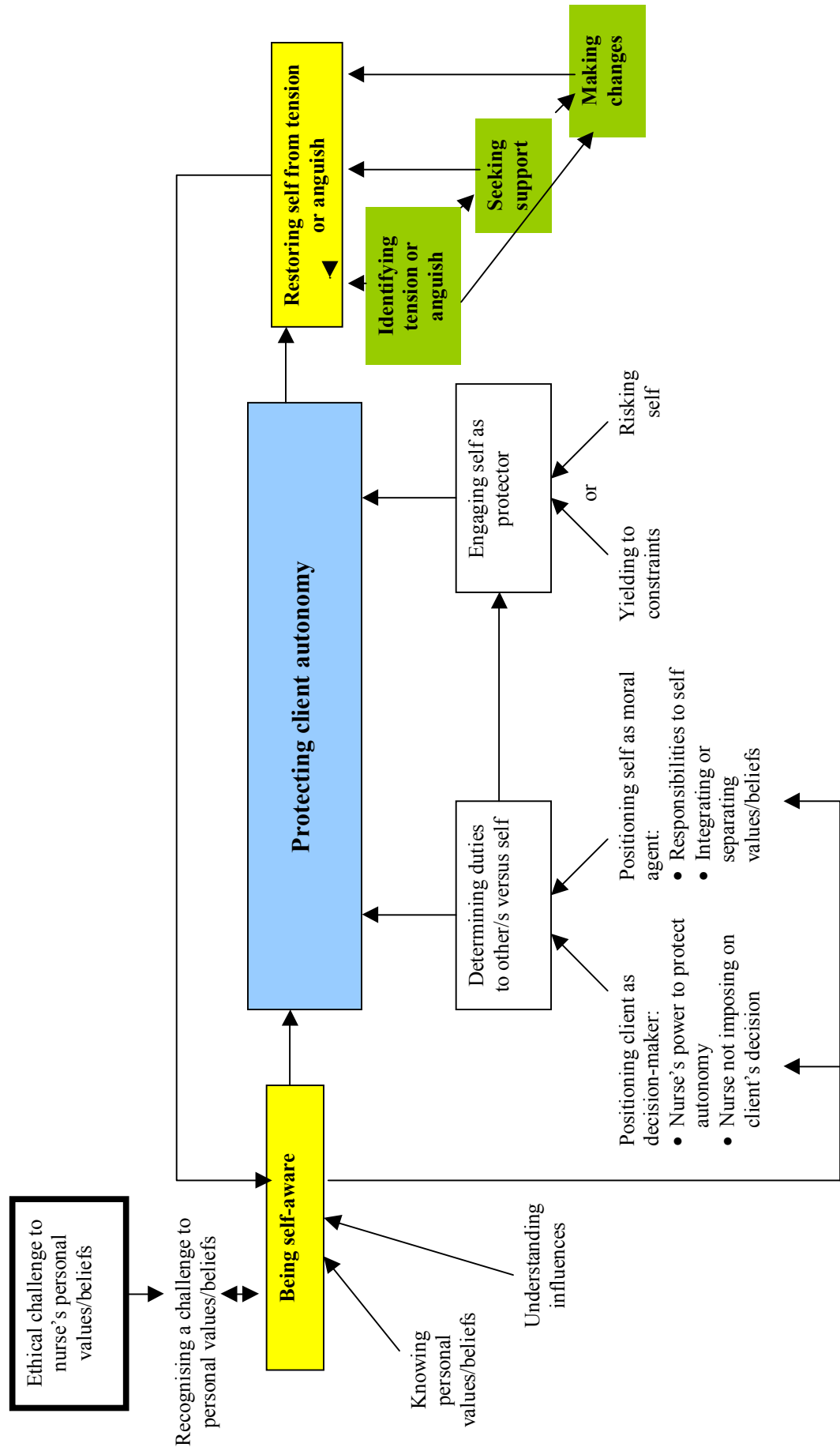
Figure 8.1: Category 4 – 'Restoring self from tension or anguish' and its place in the theory

Identifying tension or anguish

Webster and Baylis (2000) use the term 'moral residue' when describing situations where health care professionals compromise integrity in the face of moral distress. They identify moral residue as "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Baylis, 2000, p. 218). The outcome for the professional in such situations can at times be severe. Webster and Baylis (2000) suggest "the experience of compromised integrity that involves the setting aside or violation of deeply held (and publicly professed) beliefs, values, and principles can sear the heart" (p. 223). Data in the current study indicate that such situations occur in the nursing environment and can have personal consequences for nurses.

Nurses experience a variety of reactions as a result of dealing with ethical challenges with a focus on giving priority to client autonomy. These reactions usually exhibit themselves as emotional reactions. Where nurses believe they have acted appropriately and they are satisfied with the outcome for themselves and the client, they are likely to experience emotions that are positive.

> *And so the decision-making you're comfortable with and you go away feeling happy. [Amanda].*

> *I was happy. I was at peace. And I was even surprised myself at the satisfaction of knowing the patient had the priority, [it] was fantastic. [Chloe].*

However, even in situations where nurses believe they have done the right thing, they may still feel emotionally or physically drained because of the energy they have had to expend during the incident.

> *And I was proud of myself because I didn't back down. But then you look at it and you think I shouldn't have had to have fought so hard. [Carlee].*

> *It's not always easy and I found that one hard, that particular one. [Jade].*

The need to restore oneself from ethically difficult situations is therefore not always confined to situations where the consequences are perceived to be unacceptable.

Nor should it be presumed that nurses cannot gain anything positive from confronting ethical challenges. Some may actually find improved discernment and clarity in relation to what they will or will not accept in the future and as a result mature from the experience.

> *Nursing generally, like with me I think it's actually mellowed some of those strong views I've had and I think a lot of people I've experienced in nursing it seems to have done similar things. [Tim].*

However, in circumstances where nurses are not satisfied with an outcome, especially when they believe a client's autonomous choice or welfare have been compromised, they can be left with negative feelings such as frustration, distress, or anger.

> *Well I was angry. I was angry with the doctor for not doing anything. I was annoyed with the nursing staff that they kind of didn't back me up. [Michelle].*

> *So we were left with such a dilemma, so angry ... just, you know, absolutely devastating for us.... We were so angry and disappointed about what we saw as a breach of duty of care ... and at the time we were, we never felt so impotent and so just, so useless ... [we] spontaneously just burst into tears. So there we were the three of us standing in the intensive care unit crying. I mean we, it was just the culmination of our complete distress. [Katelyn].*

The emotional effects may be short lived. However, they can also remain for a long period of time and may affect a nurse's ability to carry out his or her role effectively.

> *I was emotional and it impacted me for a long time after that incident ... it was hard to go to work, it was painful. It impacted my performance in different ways. [Chloe].*

In some situations, dealing with ethically challenging experiences, or a culmination of experiences, may be so stressful that nurses suffer health problems as a result.

> *Some people might be able to cope with that but what about the ones that don't ... you've got huge stress and you've got little backup and support ... everyone's on survival mode. [Holly].*

It is important these reactions are identified and assessed so they can be dealt with appropriately if negative consequences are to be avoided in the long-term.

Webster and Baylis (2000) contend that compromising one's values and beliefs can have acute consequences including distress, fear and remorse, and these

effects are not necessarily short-lived. Individuals may find that, for them, the consequences last several years and in some instances even a lifetime. Evidence in the current study data indicates that nurses may suffer long-term effects from being ethically challenged.

> *And it was disturbing so I gave up nursing at that stage ... and to this day it still upsets me to think about it. [Lauren].*

> *I felt dreadful.... I can't remember how the others felt and what we said to each other, but I know that has been something that's sort of stayed with me. [Amanda].*

In order for nurses to deal with the effects of ethically problematic situations they need to be aware of how such situations can affect their emotional, psychological and social dimensions. Failure to appropriately recognise and manage any resulting loss to personal values, integrity, or work related relationships can have ongoing implications both personally and professionally (Raines, 2000). To deal with these some nurses seek support and develop coping strategies. This at times leads them to making personal or professional changes in order to deal with the ensuing tension or anguish. Alternatively, some nurses choose to make changes without necessarily seeking support first.

Seeking support

When nurses are ethically challenged they are likely to seek external reassurance or support. Such support can be formal or informal, depending on the nurse's individual preferences, the cause of the tension or anguish, and whether or not support is available in the work environment.

Support within the work environment

Immediate support is often required by nurses when they experience the emotional effects of a challenging situation in the work environment. Because of the nature of nursing work this is not always considered practical. Where it does occur it is generally provided informally amongst the staff on the ward where the situation has occurred, but usually does not include somebody formally qualified to help people deal with situations that may be traumatic or stress-inducing.

I've been pretty protected in my nursing career. I've worked in a great ward and had a great NUM [Nursing Unit Manager] who really addressed issues and was really very caring about her staff and would, if she sensed a problem she was quite up front about going up and talking about it. [Rachel].

At most places I've worked at there's been staff that I've identified with fairly well that we can actually talk things through fairly well. [Tim].

For many nurses, the opportunity to dialogue about ethical issues with fellow colleagues, or with somebody in the work setting they consider to be a mentor, is considered to be valuable support. Such discussions provide the chance to consider various opinions and attitudes and to reflect on what is personally important.
Having supervisors, such as nursing unit managers, who ensure appropriate support is available when required, and who additionally act as mentors, is also beneficial.

In some work settings nurses have appropriate formal support available to them. These environments tend to be specialised settings where it is recognised that staff members are likely to have personal values/beliefs challenged on a regular basis.

So this setting actually suits me better because it's well discussed and well, we get right into it and everyone has an opinion ... and you have an opportunity to change what other people might think.... You can voice your opinion but it's not just this is what I think, it's more like you can debate something where you might get change. And it might be change on my part too, someone else might change my opinion.... I think that's pretty unique to this area. [Kylie].

We have EAP for debriefing ... which is an external program that we can call in at any time or that anyone is free to go to. So if one wanted to avail oneself of formal debriefing counselling ... you are encouraged to and it's there so you can do that. I tend to run a unit where debriefing goes on all the time. [Alisa].

Formal programs and forums have been set up at some institutions where nurses can get support if required. Although such support may not be available immediately to nurses at the time they are actually dealing with the challenging situation, being able to subsequently access it can provide a level of support.

We actually have forums, the DON [Director of Nursing] runs a forum at the place I'm working now and that is really effective ... there's actually nursing support staff at the hospital I'm at now. It, that their sole role is to support staff ... I actually talked to them about that [a case shared in interview] and they were actually quite good to sound. [Tim].

Evidence from the data in this study indicates that where nurses have appropriate and accessible support systems available to assist with challenging circumstances, there is benefit.

Unfortunately support in the work arena is not always available. In some environments it is completely lacking and so it is left to the individual nurses to seek ways of dealing with their personal reactions.

> *They didn't support me, at all. I mean a couple of them made comments to me afterward, after he'd gone but ... I just felt unsupported. [Michelle].*

> *But it's difficult. So I just don't know. I bring up this issue, I think I did the right thing, but it's getting nowhere ... and there's no support and I think that's why that bothers me, there's no support. [Yasmin].*

Although nurses accept they have a major role in caring for, and protecting their clients, there is evidence that they are not always supportive of each other.

> *I think in nursing it's important for nurses to be caring of each other as they are of their patients and to remember about, you know, like we were saying about how would you like to be cared for and looked after. [Belinda].*

If a nurse needs help and support from fellow nurse colleagues there is no guarantee it will be forthcoming.

> *No, I'd have to say no. Because I think that nursing there's always that strong, you know, you're the strong one. You don't sort of have to need anybody else, that you're the supporting person and that. So no I don't think that nurses do give enough to other nurses in lots of ways. [Lauren].*

> *I see a fair amount of horizontal violence in nursing still. Nurses, they're a cruel lot, they're pretty hard on each other.... But generally as a group they're, there's some ruthless characters abound that, you know, that yeah I think they could be a lot kinder to each other from time, in a general daily sense I mean. [Cameron].*

Finding appropriate support within the work environment can be made even more difficult when there is a lack of team cohesiveness.

> *Where they've got private rooms you're actually forgotten. Yes it's isolated. There's no team sharing, there's no team. I found the team spirit not there and so there's not a congenial group that actually support each other when they have stress. [Amanda].*

This is more likely to occur in settings where there is frequent use of casual workers or where nurses feel more isolated because the physical layout of the health facility limits regular contact with the rest of the health care team.

In situations where a nurse takes a risk and is suffering stress-induced symptoms as a result, he or she may find a lack of sympathy and support from nurse colleagues.

> *I consider that leaving the shift for an instant stress-induced migraine a complete sham and I think it is very unreasonable of Nurse A to behave in this manner after accepting the shift. There is obviously no way of changing Nurse A's view and the situation has become a no win situation. Because Nurse A is casual staffing and not employed by the Hospital as such she is able to walk if she wished however this may influence any future work in this area and indeed the institution. [A response to Vignette 1].*

This multiplies further the challenge for nurses who make such choices and may in fact make them reconsider similar decisions in the future so that they yield to constraints rather than take a risk. Lack of support may at times also lead nurses to consider changing the area in which they work or even leaving the profession altogether.

> *I know that some of the staff where I work are looking for alternatives and I myself am thinking the same. [Jade].*

> *I've seen nurses quit because of challenges they've had, from probably a [sic] ethical challenge in relationships between staff rather than direct nursing to patient care. But I've seen them actually quit. [Tim].*

Curtin (1993) urges nurse administrators to implement policies that allow nurses to have 'moral space'. Acknowledging some may be concerned this could result in moral chaos or insubordination, she argues for the importance of providing nurses with space that can assist them to maintain their own integrity. Work environments with clear policies that provide appropriate mechanisms to be followed when there are conscientious objectors, or when nurses believe their personal values and beliefs are being inappropriately challenged, can assist nurses to feel supported and valued as employees.

It is acknowledged that the availability of support systems is limited in some work environments. Nevertheless there is evidence in the study data that nurses do not always access what is available. Sometimes this is due to lack of knowledge of procedures available to them or feeling intimidated by them, or it may be because the nurses just believe it will not make a difference anyway.

> *We should have taken it to the ethics committee and said "look this is what's happening and we're not happy". We should have put in a proper sort of complaint or something.... Being able to access those I think is probably from the nurse's point of view, you know your nurses are on the ward level sometimes they wouldn't even think to take an issue like that that far. In a lot of areas I don't think they wouldn't even think. They would just be really upset about it and go home and probably cry for a week. [Angela].*

> *So they have to look at the protocol there. There is no detailed step-by-step procedure. They should ask for that, and if they complain what is the repercussion of doing that. Will they retain their job? What will happen to them? [Yasmin].*

Although support mechanisms are currently available to some nurses, it is evident from the data that they are available only at a limited level and need to be improved.

> *I think Nursing Unit Managers need to be a lot more supportive of their staff and a lot less swayed by the public opinion or administration's opinion or whatever. And if they recognise some stress symptoms I think that it, I think employees should be given stress leave ... there needs to be a lot more flexibility with stress leave. I think nurses face some very stressful situations, you know, equally stressful as the police force or anyone else who have plenty of strategies in place for stressful situations. We have nothing out there for the staff. [Holly].*

> *I don't think there are enough areas where they [nurses] can just talk about their feelings, what's happening, yeah without any judgement. [Belinda].*

> *Good to have a nurse counsellor you could go to one-to-one knowing that what you said wasn't taken anywhere else. But someone who was a nurse who knew the issues. A counsellor might be all right but I think you really need a nurse counsellor. [Jade].*

The provision of support systems within the work environment for nurses who have to deal with ethically challenging situations provides benefit to nurses who have to deal with the consequences of having personal values and beliefs challenged. Not

only can it assist nurses to deal with their personal reactions to ethical problems, it can also help them develop their skills in ethical decision-making and in identifying the actual pertinent ethical issues. On-going dialogue about ethical matters promotes reflection on one's personal attitudes and opinions and additionally exposes one to other perspectives that should be considered.

Support from others outside the work environment

If, having sought support from within their work environment, it is not forthcoming or successful, some nurses seek it from others in settings away from their work environment. Alternatively, some prefer to initially deal with certain concerns away from their professional setting for personal reasons. In circumstances such as these nurses will usually seek support from those within their personal or social network rather than from formally qualified sources. When this option is utilised it is common for nurses to use family members or close friends to help them.

> *I guess I tend to go home, share with my family, well my husband anyway, and you know debrief about it a little bit. And maybe, you know, one or two friends that are close and trusted. And just to confirm my own feelings on the situation and get feedback. [Holly].*

> *I would say from my experience a greater proportion would try and seek somebody out to at least talk about it. But it may not, it may well not be a professional person or a colleague. Someone who's a mentor for them be it a partner, be it a close friend, whoever. [Nathan].*

Whether or not it is appropriate for nurses to be discussing professional issues with others who are individuals from their personal contacts requires consideration. Confidentiality of information that should be restricted to the professional setting is put at risk when such discussions take place. Additionally, non-professional acquaintances may not always adequately understand or appreciate that complexity of some of the circumstances which cause nurses concern and may therefore be limited in their ability to provide suitable support. On the other hand, some nurses may feel personally sensitive about the issues which are causing them concern in the workplace and may be too uncomfortable, or even embarrassed, to discuss them with work colleagues. They may consider sharing such concerns with people outside of their work environment to be more beneficial and less threatening, particularly if they

believe their values and beliefs are unlikely to be challenged by the person/people with whom they are talking.

Self-support

Some nurses find benefit from activities they develop themselves to help them better understand the situation and their response to it. These are activities that are a form of self-support rather than ones which depend on another person, or other people, to assist. Such activities may be used in conjunction with strategies where nurses seek others, either within or outside of the workplace, to help support them, or they may be used as the sole method of dealing with a challenging situation. The strategy used can vary depending on the intensity of the challenge and what appears to work more effectively for the individual nurse.

Many nurses find reflection is particularly beneficial. This strategy, which involves thinking back on the incident and its various elements, can help them gain an understanding as to why they felt challenged, why they responded the way they did, and whether they believe they need to change the weighting given to certain values/beliefs, or make modifications.

> *Reflect on situations that you, where you have been challenged and think about why you, what it is about that situation that you're finding you're uncomfortable with…. See if you can find patterns in yourself that are, that give you, I suppose it's information about yourself. So 'what are my values? what do I think is the most important thing?' And I think that just by reflecting on your experience like when you are challenged it, you'll see patterns arise that sort of think right, well hang-on I'm starting to see that doing good is the most important thing to me, or social justice is the most important thing to me. [Kylie].*

> *I guess you do a lot of self-talk and that. You say that, you know, well this is seen to be the right thing to do, legally you've done the right thing…. I do a lot of reflecting, particularly after the situation…. I find that the next time I come up against a situation like that I can deal with things maybe differently, or do it the same…. I like to reflect and say well, you know, that was a good thing, that was bad. [Amanda].*

Although reflection is purported to have limitations, with recommendations to further research and better understand its application to nursing (Cotton, 2001; Greenwood, 1993; James & Clarke, 1994; Wallace, 1996), the strategy is encouraged by some nursing authors because it is considered a beneficial tool to assist nurses to learn from

their experiences (Atkins & Murphy, 1993; Cruse, 2007; Heath, 1998; Johns, 1999; Pask, 2003; Taylor, 2001; van Hooft, 2006). Heath (1998) encourages that the use of reflection not be limited to situations with apparent deficiencies as it can also be used to assist in determining the reasons why a situation went well. Johns (1999), describing the use of ethical mapping as a means of reflecting on experience, provides further support for the benefits of using reflection as a strategy to improve ethical sensitivity and to develop skills for more appropriately dealing with future ethical challenges. Reflection can enhance self-awareness and can be used by nurses to become more aware of ways they can make a positive difference to their clients (Johns, 1995; Pask, 2003). Reflecting on practice and using it to determine the motivation for particular actions is so crucial, according to van Hooft (2006), that if nurses do not use the strategy they should "not be described as caring" (p. 71). Reflective practice is also encouraged by Taylor (2001) because the insights gained can be beneficial to both the personal and professional dimensions of nurses' lives. However, she warns there are obstacles to reflection, particularly due to work practices and personal issues to do with aptitude, time, and willingness. Nevertheless, she points out it is important that nurses work at eliminating such barriers so that they can experience growth from the activity (Taylor, 2001).

Although referring to ethics consultants, Webster and Baylis (2000) point out that there can be benefit from reflecting on experiences which have caused moral distress, moral compromise and moral residue. Critical self-reflection can result in better understanding of the types of situations that challenge one's values and beliefs, and whether there has been any modification, or strengthening, of moral commitments as a result. Nurses should consider such self-reflection as imperative in order that they remain self-aware.

Some nurses use a personal journal to enhance the reflective process, gaining benefit from the actual writing process and then being able to review their journey at a later time.

> *I'm a big reflector ... I'd made some thoughts in my reflective journal and that's how I deal with what I do in my role. I sometimes find it quite difficult ... so I write it down and then, you know, you pull it apart. So it's been for me a sort of maturing in my understanding of who I am. [Katelyn].*

Through a lot of sort of personal journaling and looking at those sort of issues I think that's enabled me to sort of sit back and reflect on things and have a good look at things outside…. I know that people think it's a tedious task but it's really interesting to look back in four or five years and think 'my, how did I make that decision? I would never make that decision now.' So I think that helps self-development. [Emma].

For some nurses, resorting to understandings from, or activities associated with, their actual belief system provides them with a means to help ease any tension or anguish they may be experiencing.

Nurses Christian Fellowship helped me a lot and I did a lot of reading and stuff and looked at God in suffering…. You kind of have a few tears I think, and pray about it and look for strategies that protect yourself so you don't burn out…. I think the way you cope, I cope, is saying well God you know. I think that's what I do. I do the best I can but I just have to let God's will be done. And I don't have to answer to God about this situation, I have to answer to God about whether I do my best. [Jade].

Well I guess a lot of prayer. Because I'm a Christian I usually pray about it a lot. [Holly].

I meditate, which is prayer, and not petitionary type prayer, it's more sitting in the silence of the, and just allowing insights to come. [Krystle].

Ensuring they incorporate hobbies and physical activities into their lifestyle is for some nurses another important strategy to help them deal with the results of challenging situations.

I think the important thing was to engage in something that provided you with a mind set change … even if that was to throw yourself 100% into some domestic chores and put your favourite music on…. There are people who soak into a book and just lose themselves in that. There are others who pursue exercise in gym. There are others who will go and do some incredibly creative cooking. [Nathan].

Go for a walk. I'd go home and take the dog out. And I go to yoga once a week. [Belinda].

Unfortunately there are occasions when nurses may choose inappropriate strategies to try and help them manage the tension and anguish that may occur as a result of challenging situations. Although none of the participants in the current study

admitted to using such strategies, reference was made to the fact that nurses do at time resort to them.

> *Don't sit on it, that's it I think, don't push them down. I think that's when we get into difficulty and then we lash out or we lead to dysfunctional activities, we drink too much and go out and party and we, you know, do all those things that I'm sure, as I look at my colleagues, they don't last too long…. Their life starts to unravel and …it's just a consequence of not really understanding who you are. [Katelyn].*

Having appropriate support systems available in the work environment reduces the risk that nurses may resort to such inappropriate means of coping with any tension and anguish.

Making changes

Webster and Baylis (2000) argue that "one does not experience serious moral compromise and survive as the person one was" (p. 224). Despite attempts to use the various support strategies just identified, there are times when some nurses are unable to return to ethical comfort following an ethical challenge. They are sometimes left with longer-term feelings of tension or moral anguish that finally result in them deciding to make changes. Alternatively, nurses may immediately move to make changes when they identify they are experiencing tension or anguish, rather than seeking support first. The changes made in order to restore self from tension or anguish may be in either their personal or the professional dimensions, or a combination of both.

Personal changes

Nurses sometimes find that after they have reflected on an ethically challenging encounter, it is necessary to actually modify some of their personal values/beliefs. Those that impact in their professional role are principally relevant in terms of these changes. Some nurses come into the profession with very limited or, at times, no personal experience of some of the situations that challenge them. Actually experiencing such circumstances in their professional roles can be very confronting and force them to re-assess their stance on certain issues.

> *As a young registered nurses working in intensive care and those sort of places I was probably very supportive of the principles of euthanasia…. I suppose those experiences have changed my attitude on euthanasia…. I'm*

probably more very much in favour of passive euthanasia than the active. [Emma].

My concept of the value of life versus the dignity of life, but the value in giving somebody the quality of life versus just longevity it has definitely been challenged through some experiences I've had. It, and that's one of the values that's been modified in me. [Tim].

Issues that challenge nurses can sometimes be so confronting for them that it makes them seriously question their values and belief systems.

As I grow older I question whole religious, even God. I question God ... makes me wonder is there a God? [Emeline].

Are there any particular values that you have that you would be absolutely committed to? [Researcher].
Not anymore. [Emiline].
Okay, so this experience has made you really stop and reflect on what you think? [Researcher].
Oh yes it has, particularly the euthanasia issue. [Emeline].

If nurses are unable to reconcile perceived disparity between what they value and believe and what they observe or experience in their actual nursing role, they may make changes to their value/belief system.

At times nurses accept that, at least in relation to some ethical issues, there will always be a degree of tension and they find a means of living with that. This occurs in situations where the nurse has no power to make changes, or where there are multiple values/beliefs in conflict and, having reasoned through the issues involved, he or she is unwilling to compromise any of them. Living with a degree of on-going tension at a level that they believe is not counter-productive is viewed as the best option in the circumstance.

I mean that makes it uncomfortable for me because I know that I can't change it. And I know no matter how much you push it's something that is going to take a very long time to change. And it's purely and simply this, for legal reasons and people suing. You didn't treat my husband, 'But he came in dead', but you should have still tried. So that's, I mean I don't think I'll ever feel comfortable with that. [Carlee].

If you get too emotionally involved it burns you out, it drains you, and you can't function. And I realised it was going to impact on my ability to remain a caring professional if I didn't sort of stamp it out fairly soon. And so I basically reached a resolution point then accepted it and moved on. [Holly].

Another change strategy used by some nurses is to actively take steps to improve their level of self-belief and develop their skills in interpersonal relationships so that they feel more comfortable in voicing their own opinions when personally challenged.

> *I no longer have that fear of authority like I used to. I can still habitually go there but I'm much more able to see what's going on and change that. So I'm not likely to do something just because someone tells me anymore…. Just strengthening my character … and seeking to understand and building my own self concept and self confidence. It's taken a lot of work. [Krystle].*

Formal ethics education can, for some, help them deal more effectively with ethical challenges. This is particularly the case for nurses who completed nurse training prior to ethics content being included in the curriculum. Education that subsequently helps develop ethical decision-making skills is especially beneficial.

> *I think education's the first step in there. I think that learning about ethics is really important, and having it part of nursing courses. [Kylie].*

> *That all helps, I mean the more educated you are I think the better you deal with things. [Alisa].*

Professional changes

To deal with on-going tension or anguish, some nurses will make changes in the professional aspects of their lives. Often such change involves moving from the setting in which they currently work, to another, because the challenges are just too great, and/or support to help them deal with them is lacking.

> *I started recognising, you know, I don't want to burn out here and I could burnout with the current climate. And therefore I side-stepped and left my institution. Went to another institution… and found the same sort of things happening there…. I went into clinical support … and it's something I can turn up to and say 'yes I want to be here, yes I enjoy this'. [Holly].*

> *They've been absolutely appalled by something that's happened to them and they just, you know, it impinges on my ethical, my personal values, my beliefs, and those unethical situations so I'm just not going to fight anymore. I'm going off and be a secretary in a doctor's office. Or I'm going to do whatever I'm going to do. So that's the way they've responded in that situation. [Katelyn].*

Moving to another nursing environment where they are unlikely to encounter the situations that are particularly challenging is seen as a practical solution by some. Unfortunately, the challenge is so serious for others that they actually leave the nursing environment. This may be on a temporary basis until they feel comfortable enough to return.

> *I've been in and out of the system when those kind of things became too difficult to live with, and then gone back into the system when I felt recovered to a point where I could go back in and work amongst that and seek to change it…. I have to leave, I've left many times. [Krystle].*

However, the consequences of being ethically challenged are so personally confronting for some nurses that they leave the profession entirely.

> *The difference between my personal view, values and beliefs and what I see happening, if I can't bring those two together, if it's too hard it impinges on my health and my personal life and the battle is too big. So I choose not to fight anymore. [Katelyn].*

For some nurses there are positive changes that occur. Actual nursing experiences and the growth that comes as a result can help them mature professionally and aid them in developing strategies which better equip them to deal with future challenges. With maturity and experience they become more competent in dealing with personal challenges, especially if they have developed a better understanding of themselves and why they respond in certain ways.

> *I've grown as a nurse…. As a young registered nurse I didn't have the confidence, the knowledge, or probably the experience to be able to do that [advocate and empower]. It was more just go with the flow. So I certainly think that although the ground roots of that may have been there my ability to see that through wasn't there. [Emma].*

As a result of nursing experiences they have over time, there are also nurses who modify their understanding of issues related to their professional role. Such modifications can impact the way they carry out nursing activities. In particular it may result in them giving more focus to the client and their needs as opposed to being task focused.

> *I'm certainly not the person I was 30 years ago, 20 years ago. I don't think I am. I think that I was task orientated and I probably didn't think as much about the patient. I cared about the patient but I think I was more into getting the job done…. As I've got older I think I've got more compassionate…. I think the revelation that the patient's really in charge has evolved. [Belinda].*

The result of a change in focus from tasks to the client, and ensuring their choices are given primacy, is that the nurse will generally give priority to protecting client autonomy.

Feedback to being self-aware

As nurses experience ethical challenges to their personal value and belief systems and move through the process of dealing with them, changes can occur in their ability to recognise and respond to such challenges. Further, they may make modifications to their personal values and beliefs. This requires a feedback link from the category 'restoring self from tension or anguish' to the category 'being self-aware'. This feedback allows nurses to identify: (1) which values/beliefs are more likely to be challenged in the professional environment; (2) what strategies help them deal effectively with such challenges; and (3) any changes that have occurred to their values/beliefs. These personal insights assist nurses to remain self-aware.

Other research related to dealing with the effects of personal values/beliefs being challenged

The finding in this current study that nurses can experience tension or anguish as a result of ethically challenging experiences concurs with findings by Holly (1993). She identified that nurses can experience anguish, defining it as "personal feelings of travail when involved in a situation in which they felt powerless to assist patients or practice in a fully professional manner" (p. 113). This was more likely to occur in situations where they perceived a lack of support for their role as client advocates. Holly (1993) contends that failure to address this problem could be a reason why nurses leave certain specialty areas within nursing, or even the profession itself.

There was evidence in the current study that there can be harmful effects to nurses when they encounter morally distressing situations, and this finding adds to observations made in several other studies. For example, Wilkinson (1987) reported that experiencing moral distress can have damaging effects, both personally and professionally. Moral distress was defined in her study as "the psychological disequilibrium and negative feeling state experienced when a person makes a moral

decision but does not follow through by performing the moral behavior indicated by that decision" (Wilkinson, 1987, p. 16). Although moral distress in Wilkinson's (1987) study had a more narrow definition than moral tension and anguish in the current study, there are similarities in the resulting disequilibrium and negative feelings that ensue. Wilkinson (1987) found that as a result of moral distress, nurses may feel a loss of self-worth, experience depression, have nightmares, and develop physical symptoms such as headaches, heart arrhythmias or diarrhoea. Further, moral distress can affect personal relationships. Some of the participants in Wilkinson's (1987) study believed client care was unaffected, or was even better as a result of being morally distressed. However, others reported it was worse with some actually reporting avoidance of patients as a means of coping at times.

Harmful effects, from ethical conflicts and distress, to the personal well-being of nurses have also been found by other researchers. A study of critical care nurses by Sundin-Huard and Fahy (1999) found that the moral distress, which resulted when nurses believed their attempts to advocate for vulnerable clients was unsuccessful, could lead to burnout. The term burnout is generally used to describe a condition which involves "mental or physical energy depletion after a period of chronic, unrelieved, job-related stress characterised sometimes by physical illness" (Harris, Nagy, & Vardaxis, 2006, p. 262). Additionally, Sundin-Huard and Fahy found nurses suffering moral distress may find they are moved to another location in their work place, or become scapegoats.

The current study finding that nurses may make professional changes in response to ethical challenges is consistent with findings by other researchers. Elpern, Covert and Kleinpell (2005) reported some nurses chose to move to other work areas, or seriously questioned staying in nursing altogether, in response to situations that were morally distressing. These strategies were also identified as mechanisms used by new graduate nurses to cope with moral distress in a study by B Kelly (1998). Some of the nurses in Kelly's study also identified the avoidance of patient interaction as a means of coping, which added to the personal distress they were already experiencing. This put them at risk of burnout.

That there can be long-term effects from being ethically challenged supports conclusions by Fry, Harvey, Hurley and Foley (2002). They found that the effects of being morally distressed were not necessarily confined to immediately following the situation, but could in fact continue over a period of time. The on-going effects could include "crying, loss of sleep, loss of appetite, nightmares, feelings of worthlessness, loss of confidence, heart palpitations, changes in body functions, and headaches" (Fry et al., 2002, p. 383). If unresolved over several years, the consequences could include the nurses actually leaving nursing practice, or burnout.

Similarly, Wurzbach (1996) reported nurses may continue to experience uncertainty and feelings of discomfort years after making a moral decision if they are unsure the decision was the right one. Referring to this as 'looking back', she identified the discomfort was "accompanied by difficulty sleeping, feeling badly, anger, and feelings of not being at peace" (Wurzbach, 1996, p. 263). The current study findings also support observations made by Wolf and Zuzelo (2006) who found that incidents which were described as "never again" (p. 1203) encounters could continue to haunt nurses for several years with painful memories. Although the nurses often learnt valuable lessons from such incidents, they had such an emotional impact on them they were considered important turning points which affected their careers from that point onward.

The finding in the current study that support is available to nurses in some settings, but not in others, concurs with observations reported by Zuzelo (2007). Further, the benefit of having a support system available when feeling ethically challenged is consistent with findings in other studies. For example, Astrom, Jansson, Norberg and Hallberg (1993) found that nurses felt better able to deal with ethically difficult care situations when they were able to share their concerns with, and receive support from, a group. Nurses were able to better grasp what was happening in the situation when they had opportunity to feel a sense of togetherness with the co-actors involved in the care of a client, especially if they had help interpreting their thoughts and feelings. Similarly, having opportunity to discuss ethical issues with other nurses was identified by a group of oncology nurses as being a particularly helpful strategy for dealing with ethical stress in a study by Raines (2000). A study of nurses from

various countries, including the US, Great Britain, and Canada, with data collected by a web-based questionnaire, likewise found the reported level of job-related stress was lower for nurses who perceived they were supported in the work place by their co-workers (AbuAlRub, 2004).

The current study also adds to observations made in a recent study of the benefits of clinical supervision to the enhancement of moral decision-making. Berggren and Severinsson (2000) studied how the provision of clinical supervision influenced the moral decision-making of a group of Swedish registered nurses whose experience in nursing ranged between one and 20 years. They reported that the nurses' abilities to make decisions were enhanced, and they were able to take more responsibility, as a result of the supervision program. Additionally, they had increased self-assurance and provided better support for their clients. The support that the supervisors provided helped the nurses to develop their self-confidence and reduced feelings of anxiety when dealing with difficult situations. In a similar study in Australia, focusing on the supervisors, it was found the nurses being supervised benefited from the opportunity to be supported by an experienced clinician because it broadened their perspectives and encouraged reflection on how they defined and solved ethical problems (Berggren, Begat, & Severinsson, 2002). Although these two studies focused on the outcomes of having supervisors available to guide registered nurses through ethically challenging situations, the benefit of having such support systems in place for both novice and more experienced nurses was evident.

If experienced, specialist nurses find the need for collegial support, this is even more crucial for new nurses. B. Kelly (1998) studied the experience of new nurses adapting to the clinical environment and found that it is important to provide them with appropriate support. Feeling that they belonged to the team was essential to these nurses as they developed their professional self-concept. The added pressures neophyte nurses face as they make the transition from student to experienced professional are such that it is crucial they receive support from their experienced nurse colleagues throughout the process.

The benefits of team cohesiveness to feeling supported in difficult circumstances in the workplace identified in the current study add to the findings by Lutzen and Schreiber (1998) of a study of Canadian nurses working in mental health settings. They reported that their participants indicated having good relationships with work colleagues and working together as a team helped when encountering ethically difficult situations. The study also revealed that, unfortunately, such environments were not common. Erlen (2001) points out that having a supportive group amongst one's peers can be beneficial for nurses when having to address moral distress. Mentors can also be helpful, particularly for young nurses who may be seeking guidance. Such support may be an important means of retaining nurses in the profession, especially in the early years after graduation (Cowin & Jacobsson, 2003).

The current study finding that nurses may not always access support systems that are available has similarities with observations by Penticuff and Walden (2000) who found that the majority of nurses in their study used discussions with other nurses and doctors as the most frequent method of helping them resolve ethical concerns. They were reluctant to take the issue beyond their immediate work environments, with only 25 per cent agreeing they would take it to an ethics committee and 10 per cent being willing to take an ethical issue to administration.

A lack of support mechanisms for nurses within some work environments was reported by some participants in the current study and this is consistent with findings in other studies. Johnstone et al. (2004), in their survey of nurses in Victoria, Australia found that only 8.3 per cent of their subjects "believed that their places of employment provided adequate resources to help them deal with ethics and human rights issues" (p. 26). Varcoe et al. (2004) reported that nurses in Western Canada found discussing ethical concerns was both personally and professionally beneficial, but the majority of those surveyed did not have the opportunity to do so. Similarly, Sorlie, Jansson and Norberg (2003), in a study of Norwegian paediatric nurses, reported that their participants lacked opportunities to openly dialogue with colleagues about ethical difficulties, and as a result felt isolated. Citing data from one participant in a study of 10 critical care nurses, Sundin-Huard (2001) asserts that nurses do not have appropriate structures in place in their work environment to

support their advocacy role. Therefore attempts to advocate for clients in ethically challenging situations can lead nurses to experiencing moral anguish and burnout if colleagues do not support them. In a study to identify why New South Wales nurses were leaving the profession, Buchanan and Considine (2002) found that there was "a diminished capacity to give and receive support amongst nurses themselves" (p. ii).

The current study found that nurses access various support systems, and what is selected at a particular time depends on a range of factors, including the type of ethical challenge, the support available in the work environment, who they feel comfortable with when seeking assistance, and the level of stress they are experiencing. This observation adds to the findings reported in a study of oncology nurses by Raines (2000). When ranking the types of support resources used, their study participants identified other nurse colleagues as the most helpful of the support systems sought to assist with dealing with ethical problems. This was followed, in order, by clinical nurse specialists, social workers, spouse or significant other, nursing unit manager, and education programs as the top six out of a total of 15. Raines' study used a survey questionnaire, a section of which asked participants to rank the support systems used from a list of 15. The participants in the current study self-reported the use of similar types of support systems as those listed in the study by Raines, further strengthening the observation made in that study.

The advantages resulting from using reflection as a strategy to help deal with responses to ethical challenges, as reported in the current study, concur with findings by Gustafsson and Farerberg (2004). Although they did not study the use of reflection for all ethically challenging situations, they found that it was a conscious activity that could be used either before or after nursing activities that "helped them [nurses] to develop and mature professionally" (p. 278). In their study the strategy, when used, focused particularly on situations where nurses considered the care of a client was inadequate, rather than reflecting on good care. The ethical issues associated with inadequate care were thought through and the nurses were able to learn and better develop their nursing skills and responses by reflecting on such experiences. Hannigan (2001) opines that the nursing profession "has seized on the idea of reflection without adequately testing its value either to practitioners or to clients and

patients" (p. 282). However, findings in the current study provide evidence that, at least for some nurses, reflecting on how they respond to and deal with ethical problems affords them opportunity to learn and mature from such encounters. As such, it is a strategy that can help them because they have been able to give focus to what has, or has not, worked for them in past situations and use that information to assist them to deal with similar or new challenges.

The current study finding that nurses may make changes to their values and beliefs is consistent with observations made by B. Kelly (1998) in a study of new graduate nurses adapting to the real world of nursing. She found that many of them "experienced alterations in ethical and moral values in the first 2 years of hospital nursing practice" (B. Kelly, 1998, p. 1142). This occurred particularly as a result of moral distress, a consequence of situations where new nurses realised they were unable to provide the type of care for their clients that they aspired to provide. In order to deal with the perceived disparity, they reassessed their professional identity and self-concept, with some making modifications to their values. This was a beneficial strategy if they were able to rationalise that the modification resulted in better skills and values than they had previously. The study by B. Kelly focused on new nurses, and the current study adds to her observations by the finding that modifications some nurses make to their values are not necessarily confined to just the first few years of nursing, although such changes can certainly occur in that time period.

That there are benefits from including ethics as a component of both undergraduate and postgraduate nursing education programs, as reported by current study participants, is consistent with findings in several other studies. Nearly two decades ago Davis and Slater (1988) asserted there was strong evidence to support the inclusion of ethics in nursing programs, and for registered nurses to be given opportunity to continue to dialogue about ethical issues once in the work arena. More recently, findings by Doane et al. (2004) also indicated that practicing nurses who had opportunity to undertake postgraduate studies in ethics found it assisted them in developing skills that were extremely helpful to their nursing practice. Dierckx de Casterle et al. (1996) reported a significant relationship between the ethical behaviour

of nursing students and education, arguing that ethical development can be stimulated in nursing students when ethical content is included in their educational experience. Similarly Krawczk (1997) found that including ethics as a discrete subject resulted in significantly facilitating the development of moral judgement for the nursing students who undertook the program. Andrews (2004) emphasises the importance of nurse managers fostering a work environment that encourages nurses to continue to develop their skills in ethical decision-making. Positive results from such an environment could include a better quality of care for clients and improved retention of staff.

The current finding that nurses may leave specific clinical areas or the nursing profession itself as a result of such encounters supports observations by Wilkinson (1987). She found in her study that nurses may change their job, or leave nursing entirely, if strategies used to deal with moral anguish are not successful. Unfortunately for the nursing profession, this was more likely to occur with nurses who were more sensitive to, and aware of, ethical issues and correspondingly felt a high level of responsibility towards their clients.

Summary

In Chapter Eight I have described the fourth category, **restoring self from tension or anguish**, in the process used by nurses when dealing with ethical challenges to their personal value and belief systems. This recognises that, as a consequence of being personally challenged, nurses may experience tension or anguish. In such situations two different strategies may be used as nurses attempt to restore themselves from the negative consequences that result from ethical challenges. One of the strategies is to seek support to help them through the process of restoration. Support may be sought from within the work environment, either on a formal or non-formal basis. However, opportunities for such support are not available in all settings. Alternatively, or additionally, nurses may choose to seek support from others outside of the work environment, or they may use activities that provide a form of self-support.

The second strategy in the restorative process is to make changes. This can involve making personal changes such as modifying personal values and beliefs, or

educating oneself further about ethics. Other strategies sometimes used are to make professional changes. This may involve changing to another work environment in an attempt to exclude oneself from particular types of ethically challenging situations, or leaving nursing altogether. If in the restorative process there have been modifications made to one's personal values and beliefs, and how they respond to them, this should be fed back to the first category, **being self-aware**. This ensures nurses continue to be aware of what their values and beliefs are, understand what has influenced any modification, and recognise when they are being ethically challenged.

In Chapter Nine I describe the core category in the substantive theory, **protecting client autonomy**. This is followed by a discussion about the reasons why nurses, when their personal value and belief systems are challenged, may choose to give priority to client autonomy and the possible implications of such actions.

Chapter 9

The Process of Protecting Client Autonomy

It's not what's right or wrong for me, it's what's right or wrong for the client. [Kylie].

Nurses have multiple values and beliefs to which they refer when making moral decisions. But when it comes to weighing them against each other primacy will generally be given to client autonomy over and above others. The result is respect for, and acceptance of, the choices made by clients even when they might be contrary to what nurses believe ought to happen.

Chapter overview

The basic psychosocial process of **protecting client autonomy** emerged from the data as central when nurses deal with ethically challenging situations and in this chapter I describe this core category. I then discuss the conditions in which the protection of client autonomy occur, the action/interaction responses nurse use that give focus to self-determinism being weighted highly, and the consequences of giving primacy to client choice. In so doing I consider the theoretical underpinnings that might explain the reasoning processes nurses use which result in them giving priority to protecting client autonomy.

The basic psychosocial process: Protecting client autonomy

Protecting client autonomy identifies the cognitive and behavioural processes used by nurses to deal with challenges to their personal values and belief systems. Client autonomy emerged from the data as the paramount value nurses consider when reasoning through and dealing with ethical challenges and is the basic psychosocial process in the substantive theory.

> *Very open to wanting to make sure that any health care decisions that I'm involved in I know that the patient is always informed and is the one in control in making the decision because it has to sit right with them or it's not going to sit right with me. [Rachel].*

> *I would consider myself a failure at my job if I couldn't set aside my own personal values and personal beliefs and give appropriate care. [A response to Vignette 1].*

> *The patient is what's important. That's what the patient wants so that's what the patient gets, regardless of what I think. [Katelyn].*

There is strong evidence that nurses are accepting of a clients' choices. This occurs in situations where they believe clients have made appropriate decisions and, additionally, when they might have contrary opinions.

In situations where nurses find their personal values or beliefs in conflict, they may well think about what they would choose to do if they were in a similar situation. However, the ethical challenge is not merely confined to this type of choice; it is more complicated than that. It can be argued there is not much of a moral dilemma in a situation where what a patient chooses is different to what a nurse may choose if in a similar situation. After all, subscribing to free will and a basic right to self-determination, as long as it does not harm others, provides easy acceptance of allowing the client's choice to be supported in such circumstances. However, the nurse's values and beliefs have an influence on what they think the client, or others, should decide. So nurses are also challenged in having to care for people, or work with colleagues or clients' families, whose decisions or actions may be contrary to what they believe ought to happen in the here and now.

> *I try to centre the decision on what the individual would want as opposed to what I want. [Emma].*

This results in more complicated moral dilemmas than would occur if it was simply a matter of accepting that different people have different views of what they might do in similar circumstances. Nevertheless, if nurses perceive client choices and rights are being compromised they accept rectifying this to be a crucial part of their role. They will usually take steps to ensure priority is given to client self-determination over and above other considerations, including their own view as to what ought to happen.

> *So I'm just trying to support them through that and if that's the decision they've chosen that's fine and we'll roll with it…. Some of the times it doesn't really matter what you think as long as you can still meet the needs of your patient. [Rachel].*

> *I think that the client's own ideas should come first and the other considerations should, you know, they've got a place and come second. [Austin].*

The priority given to protecting client autonomy is often linked to the advocacy role nurses believe they have.

We are the advocates.... I think in a lot of cases we keep the balance ... the patient's down here with little power at times. And so we have to modify that whole environment so that people don't, so the people with power perhaps don't think they can ... take advantage of their position. [Angela].

Well they're [nurses] very much a patient's advocate and I think also to ensure that the patients have been given all their right choices as number one. [Lauren].

They are cognisant of the way clients can be placed in vulnerable situations by the inappropriate use of power by others. Protector, in the context of this theory, refers to one who is able to watch over and safeguard. As advocates they believe they are in a position to help provide protection as required.

We all work under an ethical framework that is protective of the clients, and or ourselves ... it's a protective thing that we all should work on.... They're [nurses] very much a patient's advocate and I think also to ensure that the patients have been given all their right choices as number one. [Lauren].

We've got to preserve patients' rights and make sure that nothing, you know, everything goes well for them.... Patients are the ones that lose and from the nurse's point of view that's what we're there for. [Angela].

In determining what should be done nurses are focused on clients, giving priority to the protection of their decisions where there is incongruence.

I have never actually withdrawn my care because I feel my job is not to judge, it's actually to support and just make sure that they're not going to regret their decisions and that we've explored all avenues for them. Because it is not my choice. [Lauren].

The concept of client autonomy

Respect for autonomy is identified by Beauchamp and Childress (2001) as one of four moral principles considered central to ethics in health care, the other three being non-maleficence, beneficence, and justice. They propose the four values provide guidance when making ethical decisions. In describing respect for an autonomous agent, Beauchamp and Childress (2001) state that it is "at a minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs" (p. 63). The term autonomy has been used in

nursing literature to represent a variety of related concepts, including "freedom, power, control, authority, responsibility, independence and professionalism" (Ballou, 1998, p. 106). Unfortunately such broad use of the term can result in confusion and ambiguity (Aveyard, 2000). The concept of autonomy, claims Scott (1998), is highly complex and is not simply synonymous with self-rule. Rather, it is equated "to a quality of personhood" (Scott, 1998, p. 79). Benner (2003) asserts the principle of autonomy now has a high level of acceptance and nurses have a role to ensure appropriate procedures are in place to protect client autonomy.

What is 'client autonomy'?

In the current study, participants regularly used the term 'autonomy' when referring to the right individuals have to decide for themselves. In the health care environment this often includes decisions associated with their care and therapy.

> *Autonomy seems to always win out though ... it's about choice, it's about giving information and letting people make choice. So we do that ... people should feel empowered to make their own decisions.... Just presenting the whole thing so that they can make their own choices about things. So that I suppose all does come under, you know, autonomy. [Kylie].*

> *A fundamental belief in the dignity and the autonomy of people to make their own decisions ... and I support that. I believe that people can make their own decisions. [Meagan].*

However, when participants referred to clients making autonomous choices they also used other terms commonly linked to autonomy including 'needs', 'wishes', 'wants', and 'interests'.

> *Whilst I have a personal view ... I've not let that get in the way of patients' needs. [Cameron].*

> *I'd be getting information from the patient ... see what their wishes are. [Meagan].*

> *That's what the patient wants so that's what the patient gets. [Katelyn].*

> *I think that the interests of your client have to be considered firstly and the interests as they see them. [Austin].*

Although clients make choices in respect to needs, wishes, wants, interests, and the like, it should be understood these latter terms are seldom synonymous. For example, needs generally refer to that which is required in the circumstances for a particular

reason, Wishes or wants refer to what is desired by the individual but not necessarily required, or even desirable in some instances, from another's perspective. When reference is made to a person's interests it generally focuses on what may be to their advantage, rather than what they require.

Participant data in this study indicate nurses freely use these linked terms in relation to client autonomy. However, it is not always evident they pay sufficient attention to the differences between them. To simply accept that what the patient wants is in their best interest is not always appropriate from a clinical perspective. For example, giving water to a client who is nil by mouth merely because he or she expresses a wish for it is not appropriate clinical practice. Nor is it always acceptable from a moral perspective.

Data in the current study indicate nurses use the term 'client autonomy' broadly. It is not limited to the process of making choices only about what is essential in relation to current health care treatment and therapy, although that is given significant consideration. When nurses speak of protecting client autonomy they are generally referring to processes used to ensure clients can make their own self-determined choices in relation to any aspect of their care and life circumstances, based on their values and belief systems. These choices can incorporate decisions connected with needs, wishes, wants, or interests.

The status of client autonomy

Values, beliefs, principles or rights, to list some examples, are on occasion referred to as having 'absolute' status. When something is labelled such, it is accepted that nothing else can over-ride it, irrespective of the consequences (Johnstone, 2004). Nurses need to examine the status of client autonomy and determine whether or not it should be considered absolute, and why. Further, they need to be aware of potential problems that exist when it is granted absolute status.

It is apparent some nurses accept autonomy is not absolute and they place limits on its application, particularly if harm will result to the client or others:

> *Ultimately it's the patient's decision. I can't, you cannot force a person to do something against their will and I have to accept in my mind, and maybe this*

> *comes with maturity and age that this is the right thing, unless they're in danger of hurting themselves or other people. [Belinda].*

However, it is evident some consider it to be over-riding at times and are prepared to extend autonomy to situations that could be considered harmful to the welfare of a client.

> *Same with taking patients outside for their smoke when we both know it's medically contraindicated. It's their life not mine. If in their life situation, I might well make the same informed poor choice. [A Response to Vignette 1].*

The example above, from participant data, illustrates that problems can arise when nurses grant 'absolute value' status to client autonomy. This is particularly the case if there is lack of attention given to differentiating between what is appropriate for the client and what the client wants. Nurses who take this stance fail to consider the way autonomy impinges on competing values.

Autonomy is not the only ethical principle relevant in clinical practice. As previously discussed, Beauchamp and Childress (2001) also identified non-maleficence, beneficence, and justice as pertinent principles. These principles are not in a set hierarchical order, rather there is a need to balance them against each other in a given situation. There is evidence some nurses consider each of these principles, and carefully reason how they should be weighed in circumstances of conflict.

> *There's a constant balancing act ... dealing with people's autonomy and their independence and how you can grant people that, or it can be taken away. [Austin].*

Nurses are at times prepared to give lower weight to client autonomy in situations where they believe it can be justified. For example, the principle of non-maleficence requires no harm be done, and this may be given precedence over autonomy in some circumstances.

> *My own belief is that I have to have respect for whatever a person has a belief in regardless of whatever it is, as long as it does no harm. That would be my major concern. [Belinda].*

These nurses accept autonomy is a principle without absolute status and therefore it should not be is given mandatory placement above all other considerations. Although they highly respect client autonomy and take seriously their role of protecting it, they are prepared to concede other things will, at times, need to be given priority.

However, there is also evidence some nurses regard autonomy as having a pre-eminent position. They are therefore less likely to allow other principles to over-ride it, even when the client's self-determined choice can bring harm. For example, this is the case where nurses are prepared to overlook, or even facilitate, a client smoking when it is harmful to their health. If nurses take this stance they legitimise action that can put the client at risk by arguing the client has the right to have his or her autonomous decision protected.

It needs to be acknowledged there are situations when it is an irresponsible act by nurses to allow client autonomy to prevail, particularly where doing so results in harm to the client, or others, or when the treatment they choose is determined to be futile or contraindicated (Clarke, 2000; Fraser, 2004; Pellegrino, 2000; Schwartz, 1992; Taylor, 1995). In these circumstances, beneficence should take precedence over autonomy. To do otherwise is to act unethically. Nevertheless, when self-determined choices are considered to be informed and rational, those who highly value client autonomy may find it difficult to accept it should at times be limited (Buryska, 2001; Takala, 2007). However, Woodward (1998) argues that "If the primacy of autonomy and fear of paternalism undermine caring as moral agency, the traditional foundation of nursing is at stake" (p. 1051). Hyland (2002) also opines that giving primacy to autonomy over other ethical principles could result in the abandonment of clients, and leave the nurse accused of being negligent. As such, the protection of client autonomy should not always be "an absolute obligation" (Willard, 1996, p. 63), even though there are good reasons for giving it high weighting. To always unquestioningly give autonomy priority without consideration of other ethical principles and values is, I believe, ethically irresponsible.

The paradox

A paradox is evident when nurses use a process of giving high priority to protecting client autonomy in ethical situations in which they are personally challenged. Nurses readily accept that, except in rare and exceptional circumstances, they should not impose their personal values and beliefs on clients. Yet they are quite accepting of having clients impose their personal values/beliefs on them.

I am prepared to compromise my beliefs on a regular basis if that is in the best interest and the wishes of the patient. My personal beliefs come second to those of the patient. [A response to Vignette 2].

I'd consider what is best for the client. I'd get his or her opinion and I'd try to fit my practice in around their requests. [Michelle].

When personally challenged, nurses indicate a strong desire to protect what they perceive to be the moral rights of their clients as a priority, at the expense of their own moral choices. They accept this as a nursing function and are generally prepared to value respect for client autonomy more highly than their own personal autonomy.

My practice as a nurse has as number one priority the care of patients. I do not feel restricted from giving quality care of patients due to personal beliefs. [A response to Vignette 1].

There are exceptions to this, such as would transpire in conscientious objection. But examples of this occurring are uncommon and were rare in the current study data. An example is as follows:

We agreed to disagree and I declined my services for this couple. However, I set up for the procedure, I did not consent or counsel the couple and was not present for the procedure. The Doctor managed without me and he notified the couple of their results. [A response to Vignette 1].

In such circumstances nurses choose to give precedence to their own considered choices if they are able to assure themselves client safety and welfare will not be compromised. Otherwise, when dealing with challenges to their personal values/beliefs, nurses situate client autonomy in a position of eminence.

Discussion

The substantive theory which emerged from the data in this current study indicates nurses use a process that gives primary consideration to protecting the autonomy of their clients when responding to, and dealing with, situations that impact on the nurses' own values and beliefs. Possible reasons as to why nurses respond this way and potential effects of using this process are now discussed.

Strauss and Corbin (1998) have developed a paradigm to assist grounded theory researchers when analysing data. It is intended the paradigm will serve as a

framework to help collect and analyse data in a way that integrates "structure and process" (Strauss & Corbin, 1998, p. 128). As discussed in Chapter Three of this thesis, I found the framework helpful when collecting and analysing my data. While acknowledging the paradigm was designed to assist in data gathering and analysis, I believe it can also have other functions. In particular I have applied it to the organisation of this discussion section, allowing for the conditions, responses, and consequences connected with protecting client autonomy, and relevant to the substantive theory, to be explored.

Conditions in which protecting client autonomy are embedded

A large array of situations involving ethical concerns can motivate nurses to protect client autonomy. Additionally, issues impinging on the ability of clients to be self-determining, and how nurses are able to facilitate that, can influence whether nurses believe they need to engage in a protective role. An outline of these circumstances provides a description of the conditions in which protecting client autonomy are embedded.

Challenges to nurses' values and belief systems

The study data provide evidence that nurses regularly encounter ethically challenging situations, in the workplace, which encroach on their personal values and belief systems. These types of situations are diverse but overwhelmingly involve matters related to the welfare of clients and the preservation of their rights, particularly in relation to self-determination. If nurses are not self-aware they are restricted in their ability to clearly identify these ethically problematic situations, the issues involved that are causing them personal concern, and how to respond to them.

For nurses, being personally challenged is often linked to them being required to comply with decisions, made by others, which call them to act in a way that is contrary to what they believe should happen. This can include decisions made by clients, clients' significant others, other health care professionals, or management. In some cases it occurs in environments where nurses are overworked due to limited staff numbers and where they are frustrated because they are unable to give the level of care they desire (Erlen, 2004). Further, there are some environments and circumstances which afford nurses little power to be involved in the decision-making

process, limiting their ability to have any influence on the decisions made (Corley et al., 2005; Doane et al., 2004; Hilden et al., 2004; Oberle & Hughes, 2001; Penticuff & Walden, 2000; Spence, 1998). The actual nature of ethically problematic circumstances also varies greatly, and includes both everyday activities and the more complex issues that are less common.

When nurses who highly value self-determination encounter situations requiring them to proceed in a way, based on the decisions of others, that is not congruent with their own autonomous choice it is not surprising they feel personally challenged. This also occurs if they observe situations where the autonomous choices of clients are being undermined. One of the features of the clinical environments in which many nurses work is that several individuals need to interact with each other, and they each have a right to autonomy. This creates the possibility that choices will be made which are at times in conflict and so consideration will need to be given as to which, and whose, decisions should prevail. Such decisions are often related to therapy and care of clients. The value of respect for autonomy is therefore one that is central to nursing and impacts on nurses both personally and professionally.

Nurses are also personally challenged by situations that require a choice to be made between conflicting values or principles. Often these involve respect for autonomy coming into conflict with other values or principles such as the sanctity of life, respect for dignity, veracity, beneficence, non-maleficence, or justice. There are many situations in the clinical environment where there is the potential for such conflicts to occur and the intersection between ethical decision-making and clinical decision-making in some of these circumstances can further compound the challenge for nurses.

Paternalism

Paternalism is defined by Beauchamp and Childress (2001) as "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden" (p. 178). Gadow (1989) points out it occurs when decisions are made "without sufficient ascertainment of and

respect for the patients' wishes" (p. 99). In short, it is a violation of autonomy. When nurses who give primacy to clients having the right to self-determination observe it being debased, they will do what they can to protect it. This may require them to put themselves into difficult situations, and at times take risks, but they are motivated to take such action because of their aversion to a client's decision being usurped.

Nurses have not always given precedence to client autonomy. It was not until the 1980s that the ideology of client autonomy and empowerment was widely adopted in health care, at least within Western cultures (Jensen & Mooney, 1990). Prior to its emergence as an ethical principle within health care, paternalism dominated. Historically, patients were not considered capable of making decisions in relation to health care matters. They were expected to take a passive role and decisions relating to their care were commonly accepted as the responsibility of the doctor who was the recognised expert (Roberts & Krouse, 1990). The result was very often an imbalance of power in the doctor-patient relationship (Brody, 1980). This was commonly referred to as paternalism and may, at least in part, be an impetus to nurses now giving priority to protecting client autonomy.

Historically, using one's power to supersede another's decision had been argued as justifiable if it resulted in a benefit to the one whose decision was overridden. Doctors in particular have used this argument to justify situations where they go against a patient's decision, or make no attempt to determine the person's choice in the first place. Support for paternalism is usually couched in the term 'best interest' where health care clients' expressed wishes are overturned with the justification that they are incompetent of making decisions which are for their own good (Rose, 1995). Tweeddale (2002) argues there is still a need for the covert use of medical paternalism because doctors are the experts and they need to guide patients in decision-making. Engelhardt (1996) asserts that "given particular value commitments, paternalism should not be avoided" (p. 321), pushing for its necessity particularly in the treatment of infants and those with cognitive impairment. What must be considered from a moral perspective "is the extent to which paternalism in health care is allowable and desirable" (Engelhardt, 1996, p. 321). Working to benefit the clients, or to give consideration to their best interests, is viewed by proponents of paternalism

as justification to diminish autonomy especially if it is believed choices are inappropriate or irresponsible. I would argue benevolent paternalism does have a place and is not automatically contrary to the best interest or autonomy of clients. For example, it is considered both clinically and morally appropriate to medicate psychotic patients, contrary to their wishes, in order to improve their mental status so they can make reasoned and informed decisions about their subsequent care. However, while it can be argued paternalism may be used for the good of another, it must be recognised it can also be used to control another and is therefore open to abuse (Cody, 2003).

Cody (2003) contends that paternalism is currently found in various practices within health care, and suggests it may in fact be on the increase. This is despite the criticism it received in the 1970s and 1980s when the issues of patients' rights, individualism, and concern about the abusive use of paternalistic decision-making began to dominate (Johnstone, 2004). Paternalism and its role in decision-making in health care is certainly still on the agenda (Beauchamp & Childress, 2001), with research evidence to indicate its existence in some settings (Doherty & Doherty, 2005). Given that health care continues to be provided in an environment where the medical model is usually the guide, the dominance of the medical profession should not come as a surprise (Roberts & Krouse, 1990).

The possibility that nurses may also take a paternalistic approach must not be discounted with research findings indicating some will consider personal experiences, values, and beliefs when making ethical decisions (Berger et al., 1991; Birch, 1998; Cassells & Redman, 1989; Grundstein-Amado, 1993; Wagner & Ronen, 1996; Wurzbach, 1996). The dividing line between advocacy and paternalism is not always clear and there is a risk nurses could inadvertently take over client decision-making processes as they attempt to fulfil their advocacy role. It is crucial they allow clients to maintain control in the decision-making process and ensure their decisions are based on accurate information, if paternalism is to be avoided (Johnstone, 2004). When nurses, under the guise of advocacy, take on too much of the decision-making for clients they run the risk of calling it advocacy when nurses do it and paternalism when doctors do it.

Promoting processes that alienate clients from making their own decisions, or giving priority to the health care professional's own stance in ethical situations is paternalism, irrespective of whether it is nurses or doctors who allow it to happen. Further, Hyland (2002) contends that "forcing the patient to accept an autonomous role could in itself be seen as a form of paternalism" (p. 478). It needs to be recognised that autonomy is not always valued or desired. Some health care clients do not want to exercise it (Sahlberg-Blom, Ternstedt, & Johansson, 2000; Waterworth & Luker, 1990), some are not capable of making reasoned autonomous decisions (Capozzi & Rhodes, 2000), and some clearly prefer benevolent paternalism (Caress, 1997). Such situations bring with them the need for careful consideration as to who should be involved in making decisions, along with the decision-making process to be used. Doctors, nurses, and patients have different interests in a situation and there is always the risk of a power differential.

Failure to ensure there is no abuse of decision-making powers or processes is a moral issue. McAlpine (1996) points out:

> Ethics maintains that it is totally inappropriate for health care professionals to make decisions for others based solely or predominantly on their own personal views … in health care there must be decision-making which goes beyond the personal values of key power players". (p. 123)

If nurses believe paternalism still exists, even if only covertly, it may give them an incentive to bestow 'protecting client autonomy' a prominent position as a counteractive measure. Nurses, since the era when they were considered servants of doctors, have gradually become more autonomous (MacDonald, 2002). This has brought with it an increasing awareness of the right people have to be autonomous agents and an increasing respect for the value of autonomy.

The advocacy role of nurses

Another factor underlying the current priority nurses give to protecting client autonomy is that they see it as a crucial part of their advocacy role (Fry & Johnstone, 2002; Gadow, 1980; Schwartz, 2002; Uden et al., 1992; Willard, 1996). Data in the current study identified advocacy as an important function, with participants

connecting it with the role they believe nurses have of ensuring clients' wishes are considered and protected. Advocacy and autonomy are closely linked in nursing because protecting client autonomy is viewed as being part of the advocacy role (Fahy, 1992, p. 12; Willard, 1996, p. 61). Winslow (1984) asserts that a major intent of advocacy is to "protect and enhance the personal autonomy of patients" (p. 38).

The emergence of client autonomy is closely linked to the adoption of patients' rights in health care in the USA in the 1970s (Mallik, 1997a). Subsequently, the issues related to the role nurses should play in relation to advocating for patients' rights began to appear in the nursing literature. That nurses should take on the role has not necessarily been universally supported, with Annas and Healey (1974) arguing that "training in medicine, law, and psychology" (p. 30) would be important in such a position. Similarly Bernal (1992) questions whether advocacy is an appropriate function of nurses, particularly because of its adversarial nature and risk of overemphasis on client autonomy. Bird (1994) proposes the use of negotiation rather than advocacy. However, in her seminal work describing the transition of nurses from novices to experts, Benner (1984) identified that nurses have advocacy power and are able to use it to enable or empower clients. Within Australia, the nursing advocacy role has been heavily influenced by literature and research from the USA (Evans, 1992). In the 1980s and early 1990s the concept was introduced into Australian nursing through nursing literature (Abramowich, 1982; Fahy, 1992; Gillette, 1988) and at various nursing and interdisciplinary conferences (Evans, 1992).

The recognition that client advocacy is now an expected part of the nurse's role in Australia was identified in 1991, in a booklet titled *The role of the nurse in Australia* (Department of Community Services and Health, 1991). Explanation of what the role involved focused particularly on the nurse ensuring clients were able to act for themselves, or where that was not possible, that clients' expressed wishes were communicated to appropriate others, and clients and their rights were protected. The moral responsibility that Australian nurses have in regard to client autonomy was also made formal with the publication of the first edition of the *Code of ethics for nurses in Australia* (ANC, 1993), and it continues to be highlighted in the subsequent edition

(ANMC, 2002). The code identifies that nurses need to respect the rights of clients to make their own decisions, make sure clients are appropriately represented by another where they are unable to speak for themselves, and ensure they have sufficient and appropriate information to make choices.

Nurses are now commonly acknowledged as having an advocacy role (Bu & Jezewski, 2006; Gadow, 1980; Hyland, 2002; Willard, 1996). Research supports the notion that some nurses see themselves as advocates, or the 'voices' of clients, a role which calls them to give precedence to clients' wishes and needs (Bu & Jezewski, 2006; McGrath & Walker, 1999; Spence, 1998; Uden et al., 1992). There is also evidence that as nurses become more experienced, they increasingly prefer an advocacy model to guide them when making ethical decisions (Erlen & Sereika, 1997; Pinch, 1985). Nurses using this model view the promotion of the well-being of clients as a major nursing responsibility with the establishment of a therapeutic relationship between nurses and clients being important to fulfil this goal.

The advocacy function of nurses is akin to the "in-between stance" (p. 30) described by Bishop and Scudder (1996). These authors contend it is through this stance nurses are able to "foster the patient's well-being" (Bishop & Scudder, 1996, p. 30) as they integrate medical treatment, institutional requirements and what the patient believes is necessary and desires. Nurses, they argue, are in a unique position to consider each of these three factors. Although acknowledging some scholars take the view this diminishes the nurse's role to one of servant-hood, Bishop and Scudder (1996) assert such a position places them well to assist the client, particularly when it comes to decision-making. Nurses are prepared to be the in-betweens when they consider it results in "efficient, effective, and attentive nursing" (Bishop & Scudder, 1996, p. 36), and believe it is morally good.

Advocacy as a nursing role has various interpretations within the literature. These include nurses taking on the role of ensuring clients' rights are protected, they have adequate and appropriate information to make decisions for themselves, and they receive the respect they deserve as humans (Fry & Johnstone, 2002). Mallik

(1997b) provides further description of the functions involved, but also points out the consequences for the nurse who advocates:

> The nurse uses personal knowledge, expertise and social position to advocate on the patient's behalf. The patient is usually passive or rendered passive and the nurse uses both direct and indirect means to achieve/attempt to achieve a successful outcome. Upholding patient/family choice and guarding against incompetent/inappropriate practices through representing and protecting the patient are dominant features of this phenomenon. Outcomes can be successful, resulting in positive feelings. Alternatively, although the outcome may appear successful, there may be negative repercussions for the individual advocate. (p. 310)

Hewitt (2002) points out that nurse advocacy is a complex concept and despite compelling arguments for viewing it as a nursing function, there are many situations where, in reality, nurses are not empowered to take on the role. She argues that "For the nurse to be in a position to empower the patient, it is necessary for the nurse to be first empowered" (Hewitt, 2002, p. 444). Data in the current study indicate nurses are at times limited in their power to advocate for clients. However, some do have opportunity to protect client autonomy and take action to ensure it happens. Further, some are prepared to take risks to facilitate the decisions of their clients being adopted. Such action is contrary to Hewitt's (2002) assertion that the nursing profession has taken on use of the term advocate to better serve its own interests over those of the client.

Gadow (1980), over a quarter of a century ago, recommended existential advocacy as "the philosophical foundation and ideal of nursing" (p. 80). Emphasising that such advocacy was not simply supportive of the patients' rights movement, she pointed out nurses were uniquely situated to provide advocacy which would be in opposition to paternalism. Her concept of existential advocacy was "based upon the principle that freedom of self-determination is the most fundamental and valuable human right" (Gadow, 1980, p. 84). She asserted that existential advocacy expressed the ideal:

that individuals be *assisted* by nursing to *authentically* exercise their freedom of self-determination … reaching decisions which are truly one's own – decisions that express all that one believes important about oneself and the world, the entire complexity of one's values. (p. 85 emphasis in the original)

Nurses, she argued, had an important and unique role to play in assisting health care clients in this regard, particularly given the profession's focus on the client as a whole. Additionally, nurses in many settings have more sustained contact with clients, providing care that often clients would do for themselves if it were not for their health dysfunction. Such intimacy affords nurses the opportunity to know the clients well enough to be appropriate advocates.

What needs to also be acknowledged, however, is the fine balance between advocating for clients and acting with benevolent paternalism. As previously discussed, nurses need to ensure their advocacy role gives focus to the protection of clients' choices rather than what nurses themselves believe to be in the best interests of clients. This must also be balanced against simply giving precedence to any wishes a client may have and justifying it as acceptable because it is part of the advocacy role. Gadow's (1980) statement "that individuals be *assisted* by nursing to *authentically* exercise their freedom of self-determination" (p. 85 emphasis in the original) is key to this concept. She does not suggest that any and all wishes of a patient should be paramount. Assisting clients in activities that are harmful to them or others, as previously discussed, would not qualify as authentic implementation of one's freedom to choose.

Nurses, as part of their advocacy function, may give precedence to client autonomy because they are aware of the many barriers that can restrict it. In particular nurses may recognise their power to allow client choices can be curtailed by organisational structures, limited monetary and staffing resources, and their own level of knowledge and confidence (Thomas, 1997). Empowering clients, particularly by providing them with information through effective communication, can help to break down some of the barriers (Martin, 1998). Nurses actively work as advocates to minimise these constraints as much as possible by keeping client autonomy at the forefront of their planning.

Action/Interaction responses to protecting client autonomy

While protecting client autonomy is the core process used by nurses when their personal values and beliefs are challenged, the extent to which this occurs as a result of significant ethical analysis and reasoning may vary between nurses. Further, there is a range of ways in which nurses may choose to act or interact in response to ethically challenging situations.

Response patterns leading to protecting client autonomy

The complex nature of ethical challenges means there is usually more to these situations than just one person's decision versus that of another. Often it is a case of nurses believing that others with whom they interact in the professional environment are acting in a way they consider is unfair, dishonest, deceitful, harmful, etcetera, and so they judge it to be unethical. As a result they are challenged because their personal values and beliefs indicate that such actions are morally wrong. Despite this, they are averse to imposing their values and beliefs on to others. This places a nurse in a situation where he or she has to respond to actions considered unethical. In such situations a number of responses are available that usually result in nurses giving precedence to protecting client autonomy and may, depending on the situation, be one of the following:

1. **Silent conformity to others' decisions**

Nurses may respond by unquestioningly accepting they have an obligation to conform to decisions made by others. This may occur because they believe it is their professional or moral duty to do so and they simply accept it as part of their role. Or, they may be in a situation where they perceive they are powerless to make a difference to what is happening anyway and so accept the status quo. Alternatively, they may silently conform because it provides them with a means of dealing with ethical challenges in way that does not require them to reason through the situation and determine their own carefully considered response.

Chambliss (1996) points out that the position nurses have in the hierarchical structure which exists in many health care organisations has allowed some nursing

actions to be considered as organisationally required rather then personally determined. As such, a nurse can:

> Protect herself [sic] from the encroachments of the hospital and the problems she finds in it; they let her feel that decisions are out of her hands, and that her own sense of ethics is safe even while she does things she may believe to be wrong. (Chambliss, 1996, p. 178)

Similarly, nurses who give priority to protecting client autonomy may feel ethically safe using a process that takes responsibility away from them and gives it to the client. Such a process allows them to morally justify doing things they believe ought not to happen because their ethical responsibility is to allow clients' wishes to take priority. It gives them permission to deny responsibility for their actions if they have to do something that is contrary to what they know to be more ethically justifiable.

This presents the possibility that 'protecting client autonomy' could become an accepted 'mantra' within the nursing profession, resulting in nurses believing they have a moral obligation to do so without adequately reasoning through the ethically challenging situation. They just accept their own choices take second place to those of their clients. For some nurses this may make the whole situation easy and morally comfortable. When required to do something that is not in harmony with their personal values/beliefs, they can simply use the argument that it is not their choice, rather, they are required to do it as part of their nursing role. They no longer have to engage in the process of ethical reasoning, giving consideration to their own values and beliefs, and making a determination based on them. They can opt out of that process because they have a professional obligation to accept that clients' decisions always take priority.

For some nurses, giving primacy to client autonomy may in fact be self-protective. They accept it is not their responsibility to make the decision and find this stance gives them ethical comfort. Such a stance is similar to what some of the subjects in Wilkinson's (1987) study reported if they saw the doctor as the decision-maker and their role as nurses was to follow the doctor's orders. These nurses followed the order because they believed they had to, and as a result experienced less guilt than nurses who believed they should have more autonomy. Similarly, there

may be some nurses who accept the stance that the client's choice should dominate because it gives them acceptable justification to go against their own values and beliefs.

If nurses give priority to client autonomy it could be argued their engagement in ethical decision-making is then reduced. For some nurses this may be a preferred option. As evidenced by the current study data, nurses regularly have to make decisions as to whether or not they will protect client autonomy, whether they are prepared personally to follow through with decisions made by others that are contrary to their own choices, or whether they will yield to constraints or risk themselves. As part of this process, they need to consider which values will be given priority. If they regularly use a reasoning process that merely requires they give priority to client autonomy, they no longer have to engage in the process of considering their own values/beliefs and how they impact on the decision because it is the client's decision. In such cases the conclusion could be drawn that the nurses are avoiding their ethical responsibilities by simply accepting that ethical decision-making is the task of somebody else, namely the client. So when nurses give priority to client autonomy, there is a possibility in some situations that it is a form of abdication of moral responsibility. The strategy may be utilised because it provides them with a way of dealing with challenging situations that circumvents the need for a deeper exploration of what is actually going on. By simply unloading the moral responsibility for the situation on the client, and accepting that the nurse's moral responsibility ends at the point of ensuring the client has the ultimate choice, the ethical challenge for the nurse is resolved. The client is the one who decides, so the nurse doesn't have to.

Nurses who respond this way choose to be silently complicit to others opinions and, in some situations, unethical actions. Although at times it brings a sense of moral comfort because they believe they are fulfilling their moral duty, this is not a guaranteed outcome. Unfortunately there is a risk of it leading to feelings of guilt, anguish, or distress. Additionally, it may lead to nurses distancing themselves from further engagement in ethical decision-making.

2. Speaking up but still complying

In these situations nurses are sufficiently bold to voice their concerns about what is happening but are not prepared to then go against the decisions of others if their opinions are disregarded. Failure to proceed with action may be linked to a lack of confidence in their own view, or to concern about the personal ramifications of following through with contrary action. When responding this way nurses believe that what is happening is morally wrong and they are concerned enough to speak out about the matter. Although the possibility exists the nurse's view will be listened to and result in change, there is also a risk this line of action could lead to it being ignored, dismissed or derided.

In voicing their views or concerns, nurses may also attempt to engage others in considering the ethics of the situation. Those who use this option attempt to dialogue with the other individual/s impacted by the situation in order to resolve the ethical problems identified. Although this may result in an outcome which is ethically more comfortable if decisions made by others are modified, it requires the nurse to take a risk. This is because it can expose him or her to various workplace consequences including the possibility of ridicule or criticism by others, ostracism, or even jeopardy to employment.

It takes courage to speak out against the opinions and actions of others and those who do so are motivated by strongly held values and ideals (Bournes, 2000; Doane et al., 2004). Not all nurses are prepared to take such action, preferring to simply comply with directions given by others even if it means they compromise personal values and beliefs to do so. However, some nurses choose to voice their opinions and encourage dialogue with others, especially when they observe actions they deem to be morally wrong. They are prepared to at least articulate their view, although they may not take the next step and actually go against what others have decided should transpire. To do so, they consider, would take more courage than they have, or be too great a personal risk.

3. Acting against others' decisions

Nurses will, at times, choose to act in a way that is counter to the decisions made by others. In general they will dialogue with those involved as they attempt to resolve the issue, but if this proves unsuccessful they will act in a way they consider to be more ethically responsible, rather than as directed. They are willing to do this because they believe others are asking them to do something that goes against their personal values or beliefs and therefore they judge the action as wrong. This type of response generally calls for risks to be taken because they are unable to predict how others will react to them behaving in a way which is divergent to what is expected. They risk reactions that can be emotionally stressful such as censure, criticism, or anger from work colleagues or clients. At times they risk their professional reputation or even their employment.

When nurses choose to act contrary to others' decisions it may be in circumstances where they believe that to do otherwise will jeopardise client autonomy. They justify their response by accepting it is unacceptable for clients' self-determined choices to be violated. This gives them permission to act in a way that will ensure clients' decisions are maintained even though it means going against the directions of others such as work colleagues or clients' significant others.

Additionally, in some situations where nurses choose to act contrary to others' decisions, they may actually conscientiously object. Having reasoned through the situation and the alternatives available, they conclude they are not prepared to compromise personal values or beliefs (Baker, 1996; Birch, 1998; Higginbotham, 2002; Johnstone, 2004). They refuse to be involved in the situation because they believe it to be unethical and their duty to self must take precedence. In circumstances such as this they decide to take this action even though it may go against client autonomy. Because of the high weighting given to the self-determined choices of clients such decisions are not made frivolously, and are carefully balanced against client safety and welfare to ensure they are not threatened.

Ethical reasoning linked to the protection of client autonomy

Nurses may resort to different approaches when they reason through ethical problems, depending on the circumstances in which the challenge is occurring. What is evident from the data in this current study is that the predominant pattern of reasoning used when personal values and beliefs are challenged involves giving priority consideration to the protection of client autonomy. Although other patterns of reasoning are apparent (for example, as would occur in situations resulting in conscientious objection) alternate patterns were not commonly referred to in the data. I will now present possible explanations as to why this pattern of reasoning is used so predominantly by these nurses.

Within Western philosophy, various moral theories have been developed to help give an explanation of, and justification for, the moral decisions people make. The four patterns of moral reasoning commonly referred to in health care literature were identified in the introductory chapter of this thesis, and a brief summary of them is now outlined. In the deontological approach to ethics, the focus is on duty and therefore rules or moral principles are the guide when deciding what is right or wrong action. In contrast, the teleological approach focuses on the consequences or outcome of action, rather than the action itself, when determining what is right or wrong (Berglund, 2007; Frankena, 1973; Freegard, 2007; Johnstone, 2004). Virtue ethics gives focus to the motives behind an action in determining if it is right or wrong (Freegard, 2007; Johnstone, 2004; Kerridge et al., 2005). Ethical principlism applies the principles of autonomy, beneficence, non-maleficence and justice to ethical situations. Beauchamp and Childress (2001), who have dominated in bringing the four principles to the healthcare context, contend that "most classical ethical theories include these principles in some form, and traditional medical codes presuppose at least some of them" (p. 12).

Because these four theoretical approaches to ethical decision-making are regularly referred to in current nursing literature and the education of nurses about ethics, the possibility exists they strongly influence the patterns of reasoning used by the nurses in the current study. In suggesting this possibility, it could be assumed I am seeking to validate my theory by making reference to other theories. That is not my

intention, and to do so is contrary to the fundamental aims and procedures of grounded theory research (Glaser & Strauss, 1967). Rather, my intention is to consider whether there is a theoretical pattern of ethical reasoning that is influential when priority is given to protecting client autonomy.

The predominant pattern of reasoning evident from the study data involved giving priority to protecting client autonomy. It would therefore be easy to conclude that ethical princi019lism is the theoretical framework underpinning such decision-making. I would argue that to leap to such a conclusion is inappropriate. Although the term autonomy was commonly used by participants, they did not refer to the term 'ethical principles' with any regularity. The other three principles, beneficence, non-maleficence and justice, were mentioned, but not nearly as frequently as autonomy or its related terms. Nor was it apparent that the pattern of reasoning exclusively considered ethical principles.

The patterns of reasoning used also suggested, at times, a deontological approach. In situations where participants identified certain core values or beliefs they would not be prepared to compromise, they were indicating particular duties to which they adhered. There were examples given by participants where, as much as they valued client autonomy, they would not allow it to always take priority because to do so would contravene certain duties to which the nurses were committed. Being guided by the obligation to adhere to values and beliefs, irrespective of the outcome, advocates a deontological approach to ethical reasoning.

The data also included evidence of a pattern of reasoning which focused on outcomes or consequences. This was particularly evident where concern was expressed that the outcome should be appropriate for the client, suggesting an application of the teleological approach to ethical decision-making. Acting to ensure an outcome that is in the best interests of the client could explain why nurses are so willing to give priority to protecting client autonomy. They see such protection as necessary to obtain what they consider to be an ethically 'good' outcome. In the context of this current study, doing the right thing was generally determined by

whether outcomes were perceived as being good for clients, in terms of meeting clients' wishes and needs, rather than what the outcomes were for nurses personally.

It could also be argued that a pattern of reasoning using an application of virtue ethics was evident. In such circumstances, protecting client autonomy is an outcome where nurses apply the virtues they consider essential in a 'good' nurse. For example, the need to show care and compassion to, and respect for, clients, was at times referred to directly in the data, and strongly linked to respecting client choice. It is possible that ethical reasoning within a theoretical framework of wanting to be good and virtuous is used, and respecting client autonomy is one way that occurs. In such circumstances nurses are prepared to relinquish their own view of what should happen because virtues such as care, compassion, altruism, fairness, respect, and enablement, to mention just a few, guide their ethical decision-making in a context where the client is central. This, they believe, makes them virtuous people, which in their view is necessary to be considered ethical professionals.

Knowledge of the various theoretical approaches used in ethical decision-making is not the only guide to understanding ethical reasoning. Nursing literature has also suggested various systematic decision-making models to assist nurses to reason through ethically problematic encounters irrespective of the theoretical approach which underpins their decisions (Bolmsjo, Edberg, & Sandman, 2006; Chally & Loriz, 1998; Johnstone, 2004; Thompson et al., 2006; Ustal, 1990; van Hooft et al., 1995). The participants in the current study made no references to any formal decision-making model or framework. This does not mean they did not use a systematic process; however, the use of any formal procedure was not evident in the study data.

Additionally, codes of ethics can provide guidance to nurses when making ethical decisions. During the interviews only one participant mentioned the application of formal codes of ethics and professional boundary guidelines, and in the vignette responses reference to the ANMC code occurred once. However, there were several examples, through the data, of the application of each of the six value

statements found in the *Code of ethics for nurses in Australia* (ANMC,2002), even though the participants did not explicitly refer to them as being in the code.

It is also important to note that when articulating the reasoning process used, the study participants did not readily utilise formal ethical language. They referred to the ethical principle of autonomy, and to a lesser extent, beneficence, non-maleficence and justice. They often described their reactions to ethical challenges by using emotive descriptors, and some found it difficult to verbalise cognitive processes they may have used to reason through ethical problems. A few identified they used the maxim 'how would I like to be treated?' or a slight variation of it: 'how would I like my mother or family member to be treated?' Such statements could indicate an element of benevolent paternalism, but it is acknowledged they were stated in the context of wanting to be treated with respect in relation to autonomous decision-making.

In summary, there was no clear evidence from the participants that they used any one particular theoretical approach or decision-making framework during their process of ethical decision-making. Although it was evident respect for client autonomy was highly valued, it is not possible to argue the application of particular ethical theories or codes as being foundational to that. What was obvious in the data was the importance participants gave to respecting the welfare and autonomy of clients. Central to this was 'caring'. This was caring that requires consideration of each client's unique needs and choices, even when it conflicts with the preferences of the nurse. This is in keeping with Benner and Wrubel's (2001) assertion that:

> Caring is dialogical, according respect for the other, shaped by the capacity of the other to receive or repudiate 'helping'. Caring practices require meeting the other in his or her particularity. The one caring does not get to determine the response of the other. (p. 173)

Rather than an application of any particular ethical theory, the emphasis given to caring in nursing over the past few decades appears to strongly underpin the approach used by the participants when they face ethical issues that challenge them personally. Care for their clients is the over-riding consideration.

Protecting client autonomy as a caring response

The participants in the current study did not indicate a detached relationship with their clients where the focus was merely on the legal, as opposed to ethical, implications in situations. Nor did they indicate that they resort to simply abdicating ethical responsibility to clients because they saw that as an easy option. The stories the participants shared, for the most part, illustrated nurses caring about the well-being and needs of clients, not merely reacting to less important wants the clients might have expressed. In several instances the nurses indicated they considered their own ethical stance about issues as well as determining if they would give priority to client autonomy. If they were prepared to give priority to their clients and not impose their own values on them, they would then do what was possible to protect client autonomy. At times this resulted in the nurses taking risks to ensure the clients' decisions or needs remained primary. Many of the participants indicated recognition that autonomy is not absolute, and that there are limits to allowing self-determined choice. Such action is not suggestive of nurses who are complacent or inept when it comes to ethical responsibilities. Rather, it is indicative of nurses who are prepared, at times, to go as far as putting themselves on the line for their clients.

It is argued that "Nursing identity is defined through caring for others" (Kirby, 2003, p. 23). Caring has several attributes, and Fry (1990) contends that in nursing, because of the focus on serving others, it is a moral undertaking. Nurses who highly value client autonomy, as indicated in the current study, give primacy to individualised care. They recognise their role in the patient-nurse relationship is to provide client-centred care. To do this they view each client as being unique with specific needs, values and experiences. Caring, van Hooft (2006) contends, is a virtue defined as:

> the comportment of the self towards others which has an inherent goal of enhancing the existence of those others.… Accordingly, nurse caring … will be the comportment of the nurse towards others with the inherent goal of enhancing the health-related existence of those others with whom the nurse has a professional responsibility. (p. 60)

Further, he points out that nurses motivated by the virtue of caring will willingly give of themselves to help those with health needs. Although this does not necessarily

entail complete self-sacrifice, it does imply that caring motivates nurses to respond in a way which gives prominence to their clients. Where client autonomy is highly valued this will extend, at times, to nurses willingly sacrificing their own considered opinions to allow clients' decisions to take priority.

Care is central to the nursing role (Benner & Wrubel, 1989; Gadow, 1980; Kirby, 2003; Swanson, 1991; Watson, 1985) and has been identified as an essential moral ideal in nursing literature over several decades (Carper, 1978a; Kurtz & Wang, 1991; Sprengle & Kelley, 1992; van Hooft, 2003). Gastmans, Dierckx de Casterle and Schotsmans (1998) contend that caring behaviour is "the integration of virtue and expert activity" (p. 53), arguing that the way nurses carry out their function, not simply the tasks performed, is what helps to give nurses their identity. When nurses accept caring as central they are prepared to let the welfare and needs of clients dominate. This then places nurses in a protective role, a position they willingly assume. Nurses who take this stance recognise they do not have an equal position with clients and so their own views cannot take central stage. This is readily accepted as ethically justifiable because of the high weighting given to caring and client autonomy. They are committed to the moral imperative to care even though this requires them to sacrifice their own opinions or choices at times.

The consequences of protecting client autonomy

When nurses choose to protect client autonomy in ethically challenging situations, there will be consequences for both nurses and clients. Some outcomes may be viewed as favourable and ethically justified. However, there is also potential for problems to occur. The potential for negative consequences needs to be acknowledged if nurses are to avoid making choices likely to bring harm to themselves or their clients.

Consequences for clients

Crucial to this discussion is to consider if clients want to have their autonomy protected. It is apparent from the current study data that the participants strongly supported client involvement in decisions about treatment and care and deemed their role of protecting client autonomy as important. There was no apparent consideration as to whether or not it was appropriate to do so. This raises an important question in

relation to protecting client autonomy: When giving primacy to what they regard as client autonomy, how aware are nurses of the level of participation in decision-making and autonomy clients want? Since it cannot be assumed clients want their autonomy protected, and clients were not included as participants in the current study, I will discuss and clarify what is known from the literature about clients' perspectives in this regard.

The notion that nurses should always support client autonomy can bring risk to the well-being of clients. Being non-judgemental can preclude preventive and health educative approaches to health care. It could result in failure to pronounce health risks such as smoking and obesity as bad, and exclude anti-smoking and dietary advice as crucial to the well-being of certain patients. Clients cannot always be trusted to make decisions which are in their own best interests, and at times they lack the capacity to do so in a way that can be considered to be a reasoned decision (Capozzi & Rhodes, 2000). Nurses have an important role in morally engaging with their clients. This involves developing a therapeutic nurse-client relationship conducive to assisting clients through the process of making decisions (Stein-Parbury, 2005). So to simply accept the stance that 'it's their decision, not mine' is not necessarily morally responsible.

Autonomy is now considered a key value within modern Western cultures, but it is essential to acknowledge it may not be regarded in the same way within all cultures or situations (Staunton & Chiarella, 2003). Failure to consider cultural influences may in fact result in some clients having their freedom of choice hampered. This is particularly the case where collective decision-making is given status over individualism and therefore the western concept of autonomy may be alien, or at least seen as being of lesser importance than other concerns (Barnes, Davis, Moran, Portillo, & Koenig, 1998; Freegard, 2007; Glick, 1997; Hanssen, 2004; Oliffe, Thorne, Hislop, & Armstrong, 2007; Shaibu, 2007).

There can also be different expectations in various countries as to the role of nurses in giving information to assist clients in decision-making, as well as the client's role in actually making decisions (Kendall, 2006; Leino-Kilpi, Valimaki,

Dassen, Gasull, Lemonidou, Schopp et al., 2003; Leino-Kilpi, Valimaki, Dassen, Gasull, Lemonidou, Scott et al., 2003; Suhonen et al., 2003; Valimaki et al., 2004). Despite such differences, findings suggest that nurses who support client autonomy are more likely to provide clients with information which will assist them in making decisions and seek to provide opportunities for involvement in such. Given the increasing movement of nurses between countries for work, it is important they are aware of any differences in perception of autonomy and decision-making opportunities clients may have in various countries, and are sensitive to the situation in the particular environment in which they are working (Crigger, Brannigan, & Baird, 2006; Fry & Johnstone, 2002; Goopy, 2005; Leino-Kilpi, Valimaki, Dassen, Gasull, Lemonidou, Scott et al., 2003).

Participation in decision-making is more likely to occur in environments where clients feel emotionally secure, they perceive nurses are taking seriously their right to be involved (Ashworth, Longmate, & Morrison, 1992), and the nurses both empower and facilitate client decision-making (Jewell, 1994). Clients may feel compelled to change their treatment preferences if they believe nurses caring for them do not support their choices (Carlton, Callister, & Stoneman, 2005). However, clients may not have as strong a belief in, or wish for, self-determination as nurses expect (Kim et al., 1993), or they may lack the capacity to make autonomous decisions (Capozzi & Rhodes, 2000; Tonelli, 2005). Alternatively, they may wish to make contentious, self-determined decisions in circumstances assessed by others as being futile (Zanchetta & Moura, 2006). Recognition of, and sensitivity to, such situations is essential when client autonomy is highly valued by nurses.

There is evidence that health care clients can be more satisfied with the decisions made when they are included in the decision-making process about their treatment (Ramfelt & Lutzen, 2005). However, the level of involvement wanted in the decision-making process can be affected by a variety of factors including how ill the person is (Biley, 1992), and their "age, social class, and educational level" (McKinstry, 2000). Some health care clients, while desiring involvement in decisions about everyday issues, are happy with a more passive roll when the decision involves technical matters (Biley, 1992). It is also essential for nurses to recognise clients may

change their mind about the level of involvement they wish to have, depending on their health circumstances at the time (Kim & Kjervik, 2005; Sahlberg-Blom et al., 2000). In situations where patients are prepared to let go of decision-making and entrust it to others, they may want to continue to have control by deciding which choices are relinquished, when it happens, and to whom choices are entrusted (Bottorff et al., 1998). When some are no longer capable of maintaining control over their end-of-life decisions, they want to be assured their appointed proxy will retain control (Singer et al., 1999). It is therefore inappropriate to presume all clients want to be the primary decision-maker in all situations.

Some studies support the view that patients want to be involved in decisions concerning their treatment, particularly in relation to advance directives and end-of-life care (Edinger & Smucker, 1992; Heffner & Barbieri, 2000; Kerridge, Pearson, Rolfe, & Lowe, 1998; Singer et al., 1999). However, there are also studies which indicate a preference for others, such as family members or doctors, to make healthcare decisions (Waterworth & Luker, 1990), or at least to assist with the process (Agard, Hermeren, & Herlitz, 2000). When it comes to making decisions about their health matters, it is apparent some patients have clear boundaries as to the issues in which they should have involvement. Some want the physician to be the problem solver, but alongside that they want information and involvement in decision-making (Deber, Kraetschmet, & Irvine, 1996). The ability to differentiate between what a client sees as a problem to be solved and a decision to be made is evident in such situations if one is to avoid imposing unwanted tasks onto the client.

Where self-determination is offered to patients they may comply with being involved even though they would prefer not to be. Some clients desire a somewhat dependent or passive role in decision-making, rather than being required to express their wishes (Caress, 1997; Doherty & Doherty, 2005; Woodward, 1998). Caress (1997) reports that the option selected by the majority of subjects in her study was the passive option which read "I prefer that my doctor makes the final decision about which treatment will be used, but seriously considers my opinion" (p. 46). Although they wanted their opinion to be heard they were content to let the medical expert be the decision-maker. This can of course cause difficulty for nurses who observe

instances of this happening but believe that the doctor has not adequately considered the client's view. They are faced with a dilemma because they are aware the client has expressed a desire for the doctor to do the final decision-making but they also have to contend with the possibility of client opinion being abandoned.

There may also be situations where clients indicate a desire to not make their own autonomous decisions because they have insufficient information or knowledge to do so themselves (Avis, 1994). Where health care clients defer their decision-making to health care professionals it is important to determine why they are doing so. Possible reasons could include that they view themselves as lacking knowledge or they are passive about trying to obtain information by questioning. Such causes can be rectified by ensuring clients have adequate knowledge to make decisions for themselves. However, the possibility also exists that some clients are content with simply taking advice from the health care professionals because they are perceived to be the experts. Nurses who give primacy to client autonomy have a responsibility to determine the level of autonomy each client actually desires.

Consequences for nurses

It could be considered laudable, perhaps even heroic, that nurses believe they should give primacy to protecting client autonomy. In an era where there is increasing focus on self and the rights of the individual, that nurses readily give to others could be indicative of their altruism. It is evident from the data that nurses are unwilling to impose their values/beliefs on others. However, because they frequently carry out care related to decisions made by others, in particular clients and doctors, they are regularly put into situations where the values/beliefs of others are imposed on them. Paradoxically they accept this situation. They protect client autonomy, accepting it as part or their advocacy role, at times willingly relinquishing their own autonomy in the process.

However, the following questions need to be considered: What does protecting client autonomy do to the nurses? What does it do to nurses if on a regular basis they are pushed to compromise their personal values/beliefs in order to protect somebody else's autonomy? If nurses do not believe they are willingly compromising

their personal values/beliefs because they readily accept it is the clients' values/beliefs that matter, what does that do to nurses – does it diminish them as people because their opinions do not matter? What happens when a nurse says 'I believe this', but then in the workplace has to act in a different way?

Coverston and Rogers (2000) contend that caring for clients in a non-judgemental way is now emphasised in nursing. However they express concern that for many nurses "this may translate into a belief that along with providing nonjudgemental care, they may not disagree with what the patient decides" (Coverston & Rogers, 2000, p. 6). Nurses who accept this stance run the risk of having to work in conflict with their own personal values/beliefs or of even abdicating any moral responsibility in their practice. Additionally, they are more open to using such attitudes as a means of escaping responsibility to themselves, quieting any feelings of dissonance with the excuse "It's their decision, it has nothing to do with me" (Coverston & Rogers, 2000, p. 6). Unfortunately, this limited respect for their own values/beliefs can expose nurses to stress and burnout. Further, if nurses accept they can function with an absence of moral commitment their respect for the ethical dimensions of nursing is reduced and it is difficult to accept that appropriate care can be provided to clients in such circumstances.

Where nurses do act contrary to what they believe ought to happen there is evidence they justify it by saying other things (law, policy, the system) or other people (clients, clients' families, professional colleagues) determine what they have to do, not the nurses themselves. If this is really the case, it opens up to question whether nursing can indeed claim to be a profession, given that one of the characteristics of a profession is that its members "have autonomy in decision making and practice" (White, 2005). Further, it opens up to question whether nurses can in fact claim moral agency if all they are doing is going along with what clients want. Berglund (2007) argues that:

> adopting a framework that gives autonomy primacy challenges the role of the health professions in defining good at all. If there was perfect liberty, a client could decide what outcome they wanted and what process they wanted to

achieve it by, and could then seek out a health professional to deliver it. (p. 76)

If nurses are always prepared to give primacy to clients' wishes, in the end they have to accept that their own values and beliefs do not really matter in the situation. As such, they're not acting as moral agents in order to do what is right for themselves; rather, they are turning the focus on what is right for the client.

It is possible nurses protect client autonomy because they consider it is an easy option. They may regard just doing what the client wants absolves them of moral responsibility. Rubin (1996) found avoiding ethical responsibility to be a mechanism used by some nurses. In a study of 25 intensive care nurses, described by their supervisors as "experienced, but not expert, practitioners" (Rubin, 1996, p. 170), it was found they did not have required skills to make ethical judgements, or they assigned decision-making responsibility to others. Where they perceived a situation to have an ethical component but were unsure what to do, they simply resorted to what the patient wanted. Rubin (1996) points out the nurses failed to distinguish between wants and needs and their meanings to the patients, and also did not believe they could influence the patients in any way. Rather, they saw "themselves as simply the means to the fulfilment of the patient's ends" (Rubin, 1996, p. 184).

However, it is evident from the data in the current study that the participants were not consciously indulging in abdication of responsibility. In fact, their experiences were often quite the opposite. Choosing to protect client autonomy frequently resulted in them experiencing increased emotional discomfort. They were prepared at times to take risks in order to help clients receive their expressed wishes, willingly taking the consequences of such actions. Given the level of distress many of the participants went through as a result of being ethically challenged, it is perhaps surprising they have chosen to remain within the profession. This is particularly the case where participants found inadequate support was available to help them deal with the personal consequences.

Data from the current study, as well as other literature (Buchanan & Considine, 2002; Johnstone et al., 2004; Sorlie et al., 2003; Sundin-Huard, 2001;

Varcoe et al., 2004), indicate that nurses in some work settings do not have appropriate or adequate support mechanisms in place to help them through ethically difficult situations. In such environments there is little opportunity, if any, to discuss what is happening to them and to determine if others are facing similar experiences. This can leave nurses feeling isolated and devalued, especially if their opinions and preferences are not acknowledged or considered. While protecting client autonomy may leave nurses feeling a level of satisfaction because clients' needs have been cared for, it can also leave them feeling a sense of personal loss that is not even validated, let alone dealt with.

Although giving priority to client autonomy can have negative consequences for nurses, it is nevertheless apparent it achieves something for them. If nothing else, it gives a sense of satisfaction because they are putting their clients' needs and wishes first. They believe they are fulfilling their advocacy role and are caring for their clients. Research evidence indicates that many nurses are dissatisfied with a work environment that often fails to give recognition to the professional skills nurses provide and that issues related to 'the system' often account for nurses leaving the profession (Buchanan & Considine, 2002; Cowin, 2002; Cowin & Jacobsson, 2003; Sumner & Townsend-Rocchiccioli, 2003). Nurses who choose to give priority to client autonomy are often working in a system where they face pressures due to lack of time and resources. Staffing levels are such that time limitations prevent them providing the level of care they want to give their clients. So if nurses give priority to protecting client autonomy it, at least in part, allows them to carry out their caring and advocacy roles, giving them a sense of satisfaction in their work.

Nurses who give priority to client autonomy, especially in difficult working environments, could be described as generous. This is the generosity which Frank (2004) suggests is missing from some forms of modern health care where the system is the organisational factor, rather than focus being on personal relationships. He points out that "Being responsible *for* can provide equitable delivery of services, but gone is the generosity that comes from feeling responsible *to*" (Frank, 2004, p. 126 emphasis in the original). Being 'responsible to' implies a relationship in which one is accountable to another and "allows us recognition of all the values that deserve to

be considered when responding to the risk that is inherent in being human" (Frank, 2004, p. 98). It is a generous act when, having considered all the values involved in a situation, nurses are prepared to set aside their own reasoned values and beliefs in order that those of their clients may take priority.

However, there is also a need to consider what giving priority to client autonomy fails to achieve for nurses. Even if nurses are acting with generosity when client autonomy is given primacy, "Generosity can go wrong when the chosen one becomes obligated to the first call, or the loudest call, and not necessarily to the call that is most needy" (Frank, 2004, p. 130). There is little evidence in the current study data of nurses having opportunity to discuss the ethics of a situation and to reason through ethical challenges to resolve them. Time is frequently used as the reason this does not occur. Often the issues are complex and are therefore consigned to the 'too hard basket'. Nevertheless, the harsh reality is that in ethically challenging situations nurses still have to act, and they have to live with the consequences of those actions. In some situations they act in ways which are poorly thought out, and on reflection may even appear to have been wrong. When nurses work in an environment with limited opportunities to dialogue about, reflect on, and reason through ethical issues and outcomes, even after the situation is over, there is a risk they will find giving priority to client autonomy becomes a path of least resistance. This can be an attractive option for nurses who are working in settings that are pressured and stressful due to multiple factors.

If nurses believe they have a duty to protect client autonomy, doing it may give them a sense of satisfaction because they believe they are fulfilling their professional obligation. However, that is not the only possibility. It may actually leave them with emotional trauma because in protecting client autonomy they have failed to find adequate resolution for themselves. If nurses are pushed to compromise their personal values or beliefs to protect the autonomy of others it can leave them with a personal burden. A simple response to that is to say it is the nurse's problem because it is his or her values or beliefs that are compromised. But that negates the personhood of the nurse. The consequences may be self-deception, accommodation, or rationalisation (Webster & Baylis, 2000). If an individual is prepared to

compromise his or her moral integrity multiple times for the sake of others, there is a risk that the "person's values become so changeable that it is nearly impossible for the person to articulate what he or she sincerely believes in. The person – a moral chameleon – becomes desensitized to wrongdoing, willing to tolerate morally questionable or morally impermissible actions" (Webster & Baylis, 2000, p. 224). This outcome for nurses must be avoided if they are to be acknowledged as caring and ethical professionals who practice with moral responsibility.

Other studies related to protecting client autonomy

The current study finding that protection of client autonomy is a primary consideration when nurses deal with personally challenging situations provides evidence of how highly nurses value self-determinism. This concurs with findings in other studies, albeit limited in number, that have concluded client autonomy is given high weighting by nurses. It is considered to be a value actualised in nursing practice as part of the process of helping clients to maintain human dignity (Fagermoen, 1997). Some studies have found that nurses give higher priority to client autonomy than do doctors (Redman & Fry, 2000), with doctors referring more to beneficence when the two principles are in conflict (Robertson, 1996). The priority given to client autonomy also adds support to Wurzbach's (1996) finding that, although nurses preferred moral comfort which resulted from knowing there was no violation of their own beliefs, there were times when they realised conviction should be given priority over comfort. "In cases like these, the conviction generally was that the resident's wishes take precedence despite possible disagreement with the nurse's beliefs" (Wurzbach, 1996, p. 263). The high weighting given to clients' self-determined choices over personal views is evident.

The priority given to protecting client autonomy, found in the current study, adds to the observations by Hilden and Honkasalo (2006) in a phenomenological study of Finnish nurses to explore how the participants interpreted client autonomy in relation to decisions about end-of-life. They reported nurses believe they need to advocate for patients, and their relatives, during end-of-life decisions, identifying a supportive role in relation to autonomy. "The supporter discourse outlined the nurses' identity of supporters, protectors and advocates of patients and relatives" (Hilden &

Honkasalo, 2006, p. 45), and recognised clients as potentially vulnerable when such decisions were being made. The participants identified their role in assisting their clients' involvement in decision-making, and ensuring that doctors were also aware of their wishes.

The finding in the current study that nurses view protecting client autonomy as an important function in their advocacy role concurs with conclusions reported in a study by Bu and Jezewski (2006). They explored patient advocacy by analysing English literature, published from 1974 to 2006 (220 articles and dissertations), about the concept. Through synthesis, a mid-range theory was proposed to assist in better understanding of patient advocacy. Bu and Jezewski (2006) identified the following three core attributes from their concept analysis: "(1) safeguarding patients' autonomy; (2) acting on behalf of patients; and (3) championing social justice in the provision of health care" (p. 101). The first attribute of safeguarding patients' autonomy gives recognition to the right of patients to make self-determined choices, based on "their values, preferences, and life goals" (Bu & Jezewski, 2006, p. 107). Evidence of this attribute occurs when nurses ensure clients are appropriately informed, enable self-determination to occur, and support clients' values and choices even in situations where they make decisions which are contrary to nurses' values and choices.

Although some studies have identified autonomy as a value considered important by nurses, there is also research indicating it is not always given the prominence the current study participants gave it. Grundstein-Amado (1993) observed that doctors and nurses in her study tended to solve ethical problems with solutions "that reflected their own ethical stance" (p. 1708). There is also evidence nurses may sometimes ignore client refusals of care or impose unwanted care on them (Aveyard, 2005). This occurs in situations where persuasion is involved with the use of pressure until submission to the procedure results, rather than persuasion to encourage voluntary choice. Such action by nurses is coercive or manipulative and is not respectful of client autonomy.

In contrast to the findings in the current study, a grounded theory study conducted in Australia to investigate the views of both nurses and patients about partnership care found that nurses did not always give priority to client autonomy (Henderson, 2003). Although some of the participants willingly shared information with clients and accepted their decisions, there were others in the study that did not. These nurses took the view that they knew what was best for clients and therefore attempted to maintain control by restricting the information they shared with clients. Information from some of the patients studied supported the fact that some nurses behaved this way, and some patients indicated that in response they resorted to just doing what the nurses wanted. Henderson (2003) found most of the nurses in her study "were not prepared to share their knowledge and decision-making powers with patients" (p. 507). However, it must be noted that Henderson's study focused on partnerships between nurses and patients, not on ethically challenging situations per se. It may be that nurses who take the view they should maintain control in decision-making about care do not feel ethically challenged about restricting client autonomy.

Limited consideration for clients' wishes was also observed in a study by Svantesson, Sjokvist, Thorsen, and Ahlstrom (2006). They investigated the level of agreement in opinions between Swedish doctors and nurses in relation to how aggressive life-sustaining treatment should be for patients, and the rationales used to support their opinions. Data were collected through structured interviews and analysed using both quantitative and qualitative methods. The four dimensions of medical, quality of life, age, and autonomy emerged from content analysis of the data to identify the rationales underpinning opinions as to whether life-sustaining treatment should be full or limited. Nurses more often referred to the quality of life dimension to justify full treatment for a larger number of patients than did the doctors, otherwise results were similar between the two groups. However, Svantesson et al. (2006) observed that patients' wishes as a rationale for opinions was identified with less frequency by the participants than were the other dimensions. The authors suggested that one explanation of this finding, which was in contrast to a previous study they conducted, was that in this latter study they interviewed participants about real patients under their care, rather than hypothetical cases. They suggested giving consideration to the wishes of clients could be "a socially desirable option"

(Svantesson et al., 2006, p. 158) that does not always transpire into the real situation. Findings in the current study would dispute that suggestion. Participants in the current study drew on real-life experiences in the clinical environment when discussing ethically challenging situations, with giving primacy to client autonomy emerging as central in their decision-making when responding to them.

A return to the stimulus for the study

In the introduction to this thesis I related a personal experience where I felt my personal values and belief system were challenged. It is a situation on which I have reflected over the years, in part because I have felt a need to re-examine it from a moral perspective, rather than from the predominantly clinical standpoint I used at the time it occurred. Having gone through the journey of exploring the experiences of other nurses who have encountered ethically challenging situations, and developing a theory to describe the processes used to deal with them, I now have additional insight into the event. At the time, as I recall the situation, I justified my decision to comply with the patient's request by determining it was appropriate not to put him through more stress when he was recovering from a myocardial infarction (a clinical decision). I recognised there was an ethical component involved, because I felt morally challenged by the request. However, at the time I did not believe I had the opportunity to voice a moral opinion with either the client or my work colleagues. In that era, and in the particular work environment, the focus was on providing effective clinical care and any challenge to an individual nurse's ethical system was not readily acknowledged. Certainly I do not recall any opportunity to discuss the ethical components of the situation, or others like it. As such I do not know how my nursing colleagues felt about his request and whether or not they too were morally challenged by it.

Although at the time I did not consciously recognise that my decision to comply with his request would result in me protecting his autonomy, in hindsight I acknowledge it did. Further, I am now aware I was prepared to compromise my own value of truth telling in order to allow his wishes to take precedence, although it was clinical reasoning rather than moral reasoning that was the background to the decision. The fact that I have, over several years, reflected back on the situation, and

at times questioned whether or not I did the right thing, also suggests I have had some ongoing moral tension about the event.

Knowing what I now know as a result of undertaking this study, I believe I would, at least in some aspects, act differently if the same situation arose again. For example, I would point out to the client my concern about what he was actually asking me to do and how it would affect me personally. In dialoguing with him I would try to determine if there was another option available that did not require me to comply with his request to be deceitful – such as requesting his girlfriend to visit at a specific time when it was known his wife would not be present. Further, I would also discuss the matter with the other nurses involved in his care so we could gauge each others' opinions and be more supportive of each other. Neither of these conversations happened and, in retrospect, that was regrettable because it resulted in me isolating myself and accepting there was only one way of dealing with the challenge. I would now also be aware of the intersection between the ethical and clinical issues and would therefore make a decision that was not entirely based on clinical concerns.

An application of the substantive theory generated from the data in the current study to this personal event has helped me better understand its ethical components. It has also helped me identify the issues involved and to more effectively consider various strategies which can assist me deal with other ethically problematic situations. Additionally, while conducting this study I have experienced reassurance from the knowledge that I am not alone in encountering challenges to my personal values and beliefs in the professional environment and in having to deal with their consequences.

Summary

I have, in Chapter Nine, presented a detailed discussion about the basic psychosocial process, **protecting client autonomy**. This emerged as central in the substantive theory which explains processes used by nurses when they encounter ethical situations that challenge their personal value and belief systems. Nurses use the term 'client autonomy' broadly, often applying it beyond decisions about what is required to also include client wishes, wants and interests. Paradoxically, they are

usually willing to give client choices higher weighting than their own when there is incongruence.

There are many and varied ethical situations that can be personally challenging for nurses. Because they often have to carry out activities related to decisions made by others, there is potential for them to be asked to do things which are not consistent with their own values and beliefs. Nevertheless, because they accept they have major caring and advocacy roles they are prepared to do what is necessary to protect the autonomy of their clients in many of these situations.

Nurses use various responses when they feel personally challenged. Depending on where they decide their duties lie in relation to themselves and their clients, they respond in one of three ways: (1) being silently complicit in the decisions of others, (2) speaking up but still complying with others' decisions, or (3) taking a risk and going against the decisions of others. Primary to this is guarding against imposing their own values and beliefs onto their clients. There was no clear indication from the data in this study of any one theoretical approach or ethical reasoning model used by the participants; rather, caring appears to be primary to the reasoning process used. It is apparent that care for their clients is the principal consideration that underpins the high weighting given to protecting client autonomy.

If nurses believe there is a need to protect client autonomy consideration should to be given as to whether this is what clients actually desire. Reviewed related literature indicates not all clients want to be the decision-maker in all circumstances. There are also important consequences for nurses when they give primacy to protecting client autonomy. Although such action could be considered generous and may help nurses feel they are fulfilling their role as client advocates, there can be negative outcomes. If, in order to protect client autonomy, nurses regularly compromise their own values and beliefs, or put themselves at risk, they may be left feeling a sense of loss. They may draw the conclusion that, as long as the client's decisions are upheld, their personal values and beliefs do not necessarily matter.

The finding in the current study that nurses will often give priority to protecting client autonomy when their own values and beliefs are challenged in the workplace adds to observations by other researchers that client self-determination is given high priority by nurses. However, it also contrasts with findings in some studies that indicate nurses want to maintain control of clients' decisions, and will limit clients' abilities to decide for themselves. The current study suggests this latter course of action is not likely to be taken by nurses who give high weighting to the value of respect for client autonomy.

In Chapter Ten I identify and discuss the limitations and strengths of the current study. The implications, for nurses and the nursing profession, of the findings are outlined, and recommendations for changes made. Finally, I provide suggestions for future research which should be considered as a result of the findings of this study.

Chapter 10

Implications and Recommendations

The ethics of doing ethics includes assessing the ethics of our choices to highlight some issues as important and, likewise, leave others in the shadows.

(Somerville, 2006, p. 5)

Chapter overview

I commence this final chapter by discussing the limitations and strengths of the current study. Implications the findings of the study have for nurses and the nursing profession are then identified and discussed, with consideration of the issues that exist for nurses when they have to deal with ethical challenges to their personal values and beliefs. I make recommendations for the nursing profession, particularly in relation to management and education within nursing. Finally, I propose further research, implicit as a result of the findings of this study.

Limitations and strengths of the study

Irrespective of the design and focus of research studies, they will commonly have identifiable limitations. Very few studies have the advantage of time and resources which allow sufficient depth and breadth of investigation so that limitations are excluded entirely. It is acknowledged this current study has limitations which need to be taken into account when considering the findings. However, alongside these limitations are strengths that deserve to be highlighted.

The sample size of 23 participants could be viewed by some as a limitation of the study. However, it was adequate to satisfy data and category saturation, which in grounded theory studies is the more important determinant of appropriateness of sample size, rather than participant numbers per se. Generalisation to the broader nursing community was not an aim of the study. Rather it was to generate a substantive theory from the data, and the data were sufficiently saturated for that to occur. Although the experiences narrated by the participants are unique to each individual, when analysed collectively they provided a strong base for the generation

of the theory presented in this thesis. Given that the theory emerged from the study data and involved interpretations that are conceptual and broad (Streubert Speziale & Carpenter, 2007), it should be possible to claim applicability in contexts similar to those of the participants under study.

The sample group was largely, although not exclusively, Anglo-Australian with only Christian religions represented by those who volunteered their religious belief system, so was relatively homogenous. The participants were volunteers who self-determined they fitted the eligibility criteria before indicating interest in being involved in the study. They identified for themselves that their personal values/beliefs had been challenged and the substantive theory describes the process used by such a group. It would be inappropriate to conclude that the same process is used by nurses who do not perceive a disparity or conflict between their personal values and beliefs and ethical situations they encounter in the professional environment.

Although the recruitment of participants for the study was very challenging, resulting in a protracted time for data collection, this provided strength to the data analysis process. In grounded theory, data collection and analysis need to occur concurrently. Within this process it is recommended that the data and emerging codes from each interview inform subsequent data collection. The extended time gap between many of the interviews, due to the difficulties associated with recruitment in the current study, allowed this to occur. A further strength of the study is that the procedures recommended to determine scientific rigour of qualitative studies were applied.

Implications

The study resulted in the generation of a substantive theory that provides nurses and the nursing profession with new understanding of nurses' ethical reasoning processes, from the perspective of nurses themselves. The potential for the findings to make a difference to the profession lies in the identification of the priority nurses are prepared to give to protecting client autonomy when personal values and beliefs are challenged in the work environment. Their preparedness to take risks if they observe client self-determination being usurped, and the impact of this on nurses

personally, is evident. This highlights several important implications for nurses and the nursing profession.

Theory implications

'What should I do?' is a question that dominates clinical ethics and decision-making. When seeking an answer to this question, the theory generated in this study explains that nurses who give high weighting to client autonomy use a pattern of reasoning that focuses on protecting the right of clients to make their own decisions. So in essence, the answer for them is: 'I must protect client autonomy'. However, this is not a one-dimensional process. Although self-determination by clients is considered central, it is not a matter of simply doing what the patient wants. Rather, the process is complex, requiring self-awareness, the balancing of duties between themselves and their clients, engagement with and allegiance to clients, and seeking some sense of moral comfort and resolution.

The new theory in this study provides explanation of how nurses attempt to give each of these sub-processes due attention in work environments that are multifaceted and often demanding. It illuminates the way in which there is often an intersection between the ethical and clinical dimensions of nurses' work. This calls for nurses to respond to issues where there is the potential for conflicting values, beliefs, and opinions to require consideration. The new theory offers insight into the way nurses are required, at times, to grapple with discord between their own opinions and their professional responsibilities. It identifies a process that assists nurses to work through such intricacies in a way that also accommodates their role as caring advocates of health care clients.

What was apparent from the study data is that, ultimately, the grand theories of Western ethics do not have as much impact on actual clinical practice as those who teach nursing ethics might expect. Although this does not negate the important role these theories play in understanding the nature of ethics and why there are moral conflicts and disputes (Thompson et al., 2006), application of them was not clearly evident in the generated theory. Additionally, there was little indication of the careful balancing of ethical principles against each other – for example, balancing autonomy

against beneficence. Rather, the new theory explains a process whereby nurses balance their duties, as they perceive them, to themselves against their duties to others. Through this process, client autonomy is the predominant factor that informs the nurses' reasoning and how they decide to act. Further, there was evidence of nurses dealing with ethics on a microethics level (Komesaroff, 1995). Decision-making at this level tends to be situational, unlike the classic bioethical issues which dominate ethical discourse such as abortion, euthanasia, and artificial reproductive technologies, to list a few. The associated moral concerns of these medical procedures tend to have more predictable problems which need to be reconciled. In contrast, nurses are required to make decisions that are contextual and which depend very much on specific factors such as the situation, the person/s involved, and time and resource demands. This means circumstances requiring moral deliberation can vary significantly.

This new theory suggests that nurses accept they are "charged with the protection, welfare, or maintenance of … someone" (Noddings, 1984, p. 9), and they "look for smaller, more personal, more family-like solutions to the problems of human living" (Noddings, 1989, p. 86). As such, the process links more to a care perspective rather than the more commonly identified ethical theories and frameworks. The care perspective calls for ethical reasoning that gives focus to clients and the outcomes for them (Fry & Johnstone, 2002), and which stems from professional responsibility (van Hooft, 2003). Varcoe et al. (2004) point out that as nurses "work through the messiness of everyday practice … [they] need ethical theory that can help them identify and name the nuances of particular situations and contexts" (p. 323). The new theory generated provides understanding as to how nurses accomplish this in a way where ethical decision-making and practice are enlightened by a focus on protecting client autonomy. In so doing, the process allows nurses to amalgamate their ethical and caring roles as they attempt to meet the needs of clients while concurrently reaching an acceptable level of moral comfort, despite conflicting commitments to others.

In addition to explaining a reasoning process that affords client self-determination a position of dominance in situations where there is ethical conflict, the

new substantive theory reaches the predictive level. The major prediction it makes is that nurses who value client autonomy will avoid imposing their own opinions on their clients and, where possible, allow client choices to be given primacy. It also predicts that where nurses are constrained in their ability to protect client autonomy, or they choose to put themselves on the line to ensure its protection, the probability they will experience tension and anxiety as a consequence is increased. Further, where nurses do not have appropriate means available to them for dealing with such tension or anxiety, there is a risk that their willingness to continue to work in that particular environment will diminish.

Implications for nurses and the nursing profession

Codes of ethics for nurses clearly identify that nurses have ethical accountabilities and responsibilities (ANMC, 2002; ICN, 2006). Nurses are accountable for the ethical decisions they make and their ethical responsibilities include the provision of individualised care that takes into account clients' own self-determined choices. The theory generated in this study explains how nurses are able to accomplish these professional expectations in a way that maintains a therapeutic relationship with clients, even in situations where decisions contrary to the nurses' beliefs and values prevail. It encourages moral engagement with clients and colleagues rather than benign indifference, but acknowledges nurses will at times encounter barriers beyond their control which inhibit this engagement.

The new theory provides an explanation as to why nurses are prepared to act contrary to their own values and beliefs at times. This has implications for nurses who have acted this way and, on reflection, are troubled by the experience. The theory can assist them to understand there are times when nurses find it acceptable to modify, negotiate, or even abandon their own values and beliefs because other factors are viewed as taking priority. Being aware that this process is utilised by other nurses in personally challenging circumstances can be reassuring to those who are uncertain as to whether others do likewise, and how it is justified.

Protecting client autonomy sometimes requires that nurses put themselves on the line. Such action indicates characteristics of generosity and compassion of which

the nursing profession should be proud. Nevertheless, the willingness of nurses to yield to constraints or take risks often impacts them personally. In some circumstances the outcomes of such decisions are viewed by the nurses as being positive and they are satisfied the choices they made were appropriate. However, the consequences can at times be personally stressful and support systems are not always readily available as they seek to deal with the resulting tension or anguish.

Although all participants in the current study were still working in the nursing profession at the time of data collection, some had changed the specialty area in which they were working. Others had left temporarily because of the seriousness of a challenge to their personal values/beliefs, or because of struggles they experienced as they attempted to protect client autonomy. It is conceivable there are nurses who have left the profession permanently because they have found the consequences caused such serious personal difficulties they were not prepared to continue to work under those conditions. Unfortunately, if nurses choose to leave because they perceive they can no longer protect client autonomy or provide the type of care they desire to give their clients, the profession runs the risk of losing very good and dedicated members. A profession that is already challenged by staff shortages can ill-afford to ignore the needs of nurses who, as a result of careful ethical reflection and reasoning, give priority to protecting clients and their right to self determination.

The focus on supporting client's self-determined choices may well occur because nurses accept it as a moral responsibility as outlined in professional codes. For example, the *Code of ethics for nurses in Australia* stipulates that "Nurses accept the rights of individuals to make informed choices in relation to their care.… Nurses have a responsibility to respect the decisions made by each individual" (ANMC, 2002, p. 3). Findings in this study provide evidence that, at least in some circumstances, nurses genuinely accept this is a professional obligation.

However, it should not be presumed nurses always respect autonomy as a result of careful ethical reasoning. For at least some nurses, this course of action occurs because it frees them from having to reflect on, and work through, personally troubling issues. This can happen simply because pressures in the work environment,

particularly as a result of staffing shortages or limited resources, diminish the time nurses can commit to ethical reflection and problem solving. It can also occur in situations where nurses are insufficiently skilled to reason through the ethically problematic issues or challenging situations, or because of apathy to the circumstances. Others might simply accept that a client's self-determined choice should take priority and this gives them an apparently trouble-free solution to an ethically complex situation. Such a course brings with it the possibility that nurses might at times resort to this mindset because from past experiences they have concluded that their personal values and beliefs do not warrant consideration.

Nurses risk giving insufficient consideration to the consequences of their actions and decisions when they focus on protecting client autonomy without due consideration of other issues. Added to this, and further eroding consideration of consequences, is the fact that nurses generally have to operate very much in the 'here and now'. They often work in environments where they are responsible for clients for a particular shift, or for just a few days, certainly within the acute care arenas. As such, the emphasis is on what is important now, with little consideration given to long-term outcomes. It can become more about 'what does this person want now?' rather than what is good for the person and how might the nurse be able to defend that as the right decision. The emphasis for nurses is doing their best in the time they have with their clients, which in some settings is very limited. It is evident nurses have the welfare of their clients as their focus, and want to do their best for them. However, the way in which the health care environment is arranged and organised often forces nurses to operate in the immediate situation. Acknowledgement of the long-term effects of decisions made, by both clients and nurses, does not necessarily get factored in when such circumstances exist.

If over time nurses regularly have to suppress their personal values/beliefs and are denied consideration of their own views when there are competing autonomies, it may leave them feeling a sense of loss. It suppresses their personal worth. Although this does not happen in all situations where nurses values and beliefs are challenged, findings in the study have identified it does occur. Unless appropriate strategies are put in place to help nurses through such loss they may well become complacent, or in

the long-term, suffer from burnout. Sumner and Townsend-Rocchiccioli (2003) point out that when "the emphasis is directed toward the patient; little seems directed towards the caregiver. What this means is that, potentially, the sense of self of the caregiver may be ignored, overlooked, or repressed with long-term detrimental effect on both sides" (p. 169). Unfortunately, if nurses' moral opinions are regularly over-ridden, ignored or rejected, it may lead them to abandoning their current work area or the profession altogether. The nursing profession needs to seriously consider what this does to nurses, especially in an era when there are difficulties in recruiting new nurses to the profession, and retaining those already in it.

Recommendations for the nursing profession

Recommendations, stemming from the findings of this study and the generated theory, are made in relation to nurses individually, for managers and administrators within the environments in which nurses work, and for those involved in educating nurses about ethics.

Nurses

The findings alert nurses to the need to be self-aware, particularly in relation to personal values and beliefs and what has influenced them. Such awareness is important to the process of dealing with situations that are ethically problematic. It assists nurses to recognise ethically challenging situations and to make decisions in response to them that they believe are appropriate to the situation. Nurses need to be confident in their ability to be aware of what is ethically appropriate for them, which values and beliefs they would hold to strongly if challenged, and what their moral responsibilities are to themselves.

It is helpful to see that in revising the *Code of ethics for nurses in Australia* (ANMC, 2007), a project not yet completed at the time this thesis was submitted, recognition of the importance of nurses and 'self' is apparent. The draft version of the revised code identifies 'self' as one of the four categories in each value statement (along with patient, colleagues and community). It acknowledges that nurses have personal experience and identity, along with their own beliefs and attitudes, and that these need to be recognised and valued. The importance of nurses being self-aware is

implied, particularly in situations where personal participation is questioned. It is hoped the sentiments of the code are taken seriously by each nurse and that they do not simply remain statements on paper.

Self awareness needs to be ongoing. Findings in the current study support those of other researchers (du Tont, 1994; B. Kelly, 1998; Maeve, 1998; Schank & Weis, 2001; Varcoe et al., 2004) who have identified that, over time, as a result of experiences encountered and personal maturing, an individual's values and beliefs may be modified. Nurses need to be educated from undergraduate level that this possibility exists and they need to continue to reflect on and examine their values and beliefs to remain aware of them and any subsequent changes. This is fundamental if self-awareness is to be maintained.

Each nurse needs to be clear about the position he or she individually assigns to client autonomy when weighing values and beliefs, and be able to rationalise the decision. If it is considered primary, the reason for giving it such high weighting should be apparent, its definition unambiguous, and the limits that would apply when clients make self-determined choices clearly determined and justified. The onus is on nurses to ensure decisions relating to the weighting given to client autonomy occur as a result of appropriate ethical reasoning and not simply from a sense of obligation or because it is seen as an easy solution that negates the need to engage in ethical reflection, decision-making and discourse.

Nurses need to recognise there are implications for health care clients when autonomy is given priority. As discussed in Chapter Nine, there is evidence that some clients want to be involved in decision making about their treatment and care. However, there is also evidence that some clients, for various reasons, prefer a shared approach to decision making or to have decisions made by professional experts or family members. A desire for limited involvement can be associated with insufficient understanding to make appropriate decisions, or it may be that they consider decision-making burdensome, or see others as more able. It is important that nurses determine the level of involvement clients wish to have in the decision-making process. Further,

they need to ensure clients have adequate knowledge and information to be able to make appropriate choices.

Situations where nurses consider they are powerless to be involved in ethical decision-making in the workplace, or that result in their views not being acknowledged, should be challenged. If nurses regularly encounter situations that lead them to see their personal views as irrelevant, and themselves as having little to contribute to ethical discourse, the risk is that they might end up believing their ethical function as health care professionals is to simply carry out activities determined by moral decision-making of others – be they patients, physicians or others. However individual nurses choose to act, such a situation should be unacceptable to the nursing profession.

Nursing administrators and managers

Nursing administrators and managers need to give careful consideration to the environment in which challenges to nurses' personal values and beliefs can occur, and take measures to minimise such situations. If the health care system is organised in a way that it provides nurses with little opportunity to be involved in ethical decision-making, and nurses are regularly required to carry out decisions made by others, the risk that they will be personally challenged is increased. When this is associated with an environment that does not encourage open dialogue about the ethical components of situations and the various views and opinions people have about them, there is an increased likelihood of ethical tension or anguish occurring. It is recommended that nurse administrators and managers ensure work environments afford nurses the opportunity to be involved in decisions about issues with ethical components. Further, open discussion about such issues needs to be able to occur in a comfortable setting where views can be expressed without personal condemnation.

Nurse managers and health care facility administrators need to make sure that when nurses do experience ethically challenging situations appropriate support systems are in place to assist them through any personal difficulties. Evidence in the current study indicated that nurses working in environments where such opportunities existed, either in formal or informal ways, found this provided them with valuable

support. However, some participants pointed out such opportunities were not readily available. Several expressed a need for such assistance because they believe nurses should be able to reflect on, and discuss their feelings about, ethically challenging events. If, because of the priority they give to client autonomy, nurses are willing to set aside their own moral choices, there should be opportunity to have open dialogue about the consequences they personally experience as a result of such action. How this is organised will depend on several factors including the availability of resources to assist with such a program. Nevertheless, nurse administrators and managers need to acknowledge the benefits of appropriate support for nurses when they are ethically challenged and develop methods to ensure it is provided.

When nurses encounter clinical problems they believe are beyond their expertise, they are usually able to refer to a person with expertise for assistance and advice, such as a Clinical Nurse Consultant. Likewise, nurses who encounter ethical problems in their work environment they believe to be beyond their expertise, or which are causing them acute personal distress, should have somebody with proficiency in ethics and ethical decision-making they can consult (Clark & Taxis, 2003; Jezuit, 2003). It is recommended nurse administrators ensure such a resource person is available to nursing staff. Although the ideal would be to have this person available on site, or within the institution, this would not always be practical or possible and in such cases other means of making an ethics expert available need to be explored.

Nursing Unit Managers also need to be observant of the nursing staff in their particular unit/ward and identify situations that may be ethically challenging to them. There needs to be acknowledgement that particular situations may have impinged on the personal values and beliefs of their nursing staff and opportunity should be provided for dialogue about such situations. The dialogue needs to occur in a 'safe' environment where opinions can be shared with colleagues who can be trusted without risk of moral judgement occurring, or confidentiality being broken. Ideally, the discussion should happen at the time of the event (Ashworth et al., 1992; Jezuit, 2003). However, it is acknowledged the urgency of some situations and the pressure of the work environment may preclude this at times. Where that is the case,

opportunity should at least be provided later in the shift and certainly within a few days, at most, for it to take place.

It is recommended that nurse administrators and managers give consideration to forming 'Nursing Ethics Groups' within their units or institutions, if they do not already exist. These are special forums organised for nurses to meet on a regular basis to collaboratively discuss ethical issues and ethically challenging situations, and to identify possible strategies to deal with them and their consequences. They provide an environment which encourages new understanding and perspectives with professional development occurring as they "offer opportunities to identify personal values, learn alternative perspectives, and evaluate possible solutions" (Clark & Taxis, 2003, p. 236). The objectives of such forums should include assisting nurses to develop their skills in ethical reflection and reasoning, and in limiting the risk of them becoming ethically complacent.

Administrators of health care facilities should ensure there are clear policies in place to assist nurses who make decisions not to compromise their personal values and beliefs, deciding rather to conscientiously object. They need to make sure all staff members are aware of the procedures available, and ensure that when such an option is chosen it can be followed through without risk of inappropriate ridicule or censure (ANMC, 2002; Johnstone, 2004). Nurses need to be able to work in environments where they can comfortably voice their own reasoned stance, where they can be assured their ethical decisions carry some weight, and where they are entitled to give priority to their own autonomous choices when morally justified.

Finally, in light of the findings of this study, there is a need to examine the health care system and how it impacts on the environments in which nurses work. As much as nurses may desire to do the best for their clients, this can be very difficult in work places that are poorly managed or poorly resourced. If as a result of poor management there is low staff morale, or ambiguous or deficient policies and procedures in place, there is a greater chance nurses will be ethically challenged. Unfortunately the chances of having effective strategies in place to assist them to deal with the challenges are also likely to be inadequate. Similarly, when resources are

limited there are usually reduced staff numbers resulting in a health care team that is overworked and unable to provide the care they believe is required. Again, the likelihood of ethical challenges is increased in such situations. Compounding the situation is that there is often limited time to reflect on and deal with moral problems. That nurses may resort to ethical complacency in these types of circumstances is acknowledged. After all, when 'the system' places so many pressures on staff that there is little, if any, opportunity to appropriately reason through ethical conflicts, taking an option of least resistance is perhaps understandable.

There is a need to identify and fix factors in the health care system that may cause some nurses to accept the protection of client autonomy as a mantra, or as a simple solution to complex issues they have no time to reason through. It is, however, also acknowledged many nurses give priority to protecting client autonomy as a result of careful ethical reflection and reasoning. In settings where this does occur, there is a need to ensure such opportunities are maintained and encouraged.

Educators of nursing ethics

The theory generated in this study indicates that the processes used by nurses to deal with personal challenges are complex and are not just dependent on knowledge of the classic ethical theories, principles and codes of ethics. Although it is acknowledged in the literature these should be included in ethics education for nurses (Thompson et al., 2006), the findings of the current study suggest there needs to be more. Additionally, it is accepted that despite the best efforts and intentions of those who teach ethics to nurses, it is not possible to give the necessary attention to all of the moral dimensions of nurses' work. Nor should it be expected that they can address the plethora of ethical challenges nurses will encounter within the inherent time constraints available for formal education. The onus is on those responsible for nurse education and curriculum development to recognise these limitations and to give focus to assisting nurses to develop knowledge and skills that can be applied to a diverse range of ethical situations. Additionally, the onus is on nurses themselves to identify areas of weakness they may have in relation to the required knowledge and skills and to strengthen these. The theory developed in this study provides insight into some of the topics and issues that should be included in ethics education for nurses.

This does not suggest they are not already incorporated into some programs; rather, they are given focus in this thesis to underscore the need for their inclusion in light of the findings of this study.

Educators need to ensure nurses develop understanding of the significance of self-awareness to their ability to both recognise and respond to situations that are ethically problematic to them personally. Nurses need to be able to determine their duties to themselves and how they believe they can balance these against other competing duties. This is particularly pertinent in relation to core values and beliefs that they are not prepared to compromise. Strategies are needed to determine the weighting of particular values and beliefs, personally held, when they conflict with those of others. Development of these strategies should occur within, but not be restricted to, the context of giving primacy to client autonomy and not imposing personal opinions on others. Other contexts that should be considered include legal and professional obligations, other parties involved in decision-making and the power they hold in decision-making, and circumstances of conscientious objection.

The priority given to protecting the autonomy of clients indicates that it is critical for nurses to have a comprehensive understanding of the concept of autonomy. This needs to include its actual meaning in various contexts of nursing and its implication in the nurse's role. Furthermore, other terms often used as synonyms to autonomy, such as 'needs', 'wishes', 'wants', and 'best interests', need to be well defined with clear understanding of both the similarities and differences between the terms. The onus is on those involved in educating nurses to ensure strategies are in place to assist nurses to develop this understanding. They also need to ensure nurses have opportunity to develop the skills required to make appropriate decisions when determining the weight autonomy deserves when there are other conflicting values. This should occur in a way that encourages nurses to make ethical decisions systematically, using an appropriate decision-making model (Bolmsjo et al., 2006; Chally & Loriz, 1998; Johnstone, 2004; Thompson et al., 2006; Ustal, 1990; van Hooft et al., 1995), and which takes into account the moral needs and duties of all those involved in the situation, including themselves.

When nursing students encounter the 'real world' of clinical nursing, the adequacy of appropriate support needs to be assured. Assistance to help them identify the ethical dimensions of situations and to develop strategies to recognise any challenge to, and impact on or from, their personal values and beliefs needs to be available. In view of the intersection between the clinical and ethical dimensions of nursing practice, this should occur in an integrated way during clinical placements. Clinical facilitators have a pivotal role to play in this to ensure they give focus to the ethical issues encountered. Ethics learning should not be confined to the use of hypothetical cases in the classroom setting, although their worth must not be discounted (Davidhizar & Lonser, 2003; Leget, 2004; Nibert, 2005; Thompson et al., 2006). Nurses encounter ethical issues in their everyday practice and it is important these situations be used to assist in ethics education (Berggren & Severinsson, 2000). Much can be gained "by 'localising' nursing ethics education in the actual lived-in moral domain of nursing work" (Johnstone, 1999, p. 433). Because it is difficult to anticipate when such opportunities will occur it is incumbent upon clinical facilitators to constantly observe for appropriate situations and ensure they are used to assist students in their learning. Nurses are often required to deal with ethical problems in the 'here and now' with little time for in-depth reflection and dialogue. Assisting them to recognise ethical problems and to deal with them in the immediacy of the situation is crucial to the development of their ethical knowledge and skills.

Similarly, education programs for nurses need to include opportunities for them to explore how their own values and beliefs might, or might not, impact on decisions they make in the clinical setting. The study participants indicated a strong desire not to impose their own values and beliefs on to clients. Nevertheless, when core values and beliefs were challenged a few chose to conscientiously object. Nurses need to be quite clear as to when such objection is appropriate and what constitutes acceptable moral standards (Johnstone, 2004). Those who teach nursing ethics need to ensure focus is given to differentiating between legitimate and frivolous claims of conscientious objection while also emphasising the right nurses have to refuse to participate in cases where they have strong moral disagreement (ANMC, 2002).

Consideration should also be given to further exploring the idea of interdisciplinary teaching of ethics. Although certain components may be better taught within each unique discipline, making opportunity for both nursing and medical students to explore and discuss ethical issues together can assist them to understand what each discipline considers important (Edward & Preece, 1999; Hanson, 2005). This method of teaching health care ethics has had only limited study. However, it deserves further investigation to determine if it will enhance nurses' involvement in decision-making processes, increase their confidence in communicating their personal stance, and strengthen the collaboration between health professionals in the clinical setting.

Many of the recommendations above focus on education programs for undergraduate nursing students. However, it is recognised not all registered nurses have studied ethics in their formal education. This is particularly the case for nurses who obtained their nursing qualification several years ago when nurse training did not necessarily give specific focus to ethical issues and the associated skills required to deal with them. Additionally, registered nurses who have a need, or desire, to update their knowledge and skills in ethical matters should be able to access appropriate programs. There is a need to ensure opportunities are available for these groups to undertake professional development or continuing education in ethics, where required. This could be done through various means, including seminars, workshops, and short courses. Having such programs available by flexible learning modes can also cater to the needs of nurses in more remote regions or with work commitments that have irregular hours.

Finally, it needs to be remembered by all who facilitate nurses in their learning, whether in formal classes or programs, or in the work environment, that their behaviour and decision-making activities will be observed. In essence, they are role models to their professional colleagues (Begley, 2006). They therefore need to ensure their behaviour and decisions are in keeping with professional codes and standards and that they practice ethical competence.

Recommendations for further research

The findings of the current study identified the priority nurses give to valuing the protection of client autonomy. Further study is required to investigate this phenomenon. A phenomenological study investigating 'protecting client autonomy' is warranted to explore the nature and essential elements of this phenomenon. Further, although possible reasons for giving priority to client autonomy were discussed in the thesis, there is a need to obtain further empirical evidence which explains why nurses are often prepared to do so.

The current study identified protecting client autonomy as the core category. It is evident that for the participants this was a priority value and the predominant pattern of moral reasoning. However, it is possible there are nurses who do not feel ethically challenged if they restrict client autonomy. There is a need to investigate if there are nurses who do not give client autonomy high value, and to research the processes they use when they encounter challenges to their personal values and beliefs in their workplace. Additionally, a question can be raised as to whether nurses who give priority to protecting client autonomy encounter more ethical challenges, because of the value they give to it, than do nurses who do not give it priority. Research is recommended to determine if this is the case.

There is also a need to investigate whether the priority given to protection of client autonomy is something nurses are socialised into, or whether it exists as a pattern of moral reasoning when they enter the profession. Using a similar design, further study of both 'newly' registered nurses and undergraduate nursing students is warranted to determine if they use the same or a different process to that used by more experienced nurses. Given the average age of the participants in the current study, and their level of experience in the profession, it would also be appropriate to study the processes used by undergraduate students and newly registered nurses who are recent school leavers. This would assist in identifying if there are similarities or differences in the processes used by those who are older with potentially more life experiences, and who have been influenced to a greater extent by life and nursing experiences.

An investigation into the experiences of registered nurses who have left the nursing profession as a result of having their personal values and beliefs systems challenged is also recommended. There would be benefit in gaining an understanding as to what led them to take such a step and whether there are strategies that could be implemented to prevent such occurrences.

Participants in the current study were nurses who worked in health care settings within Australia and, as such, worked in a context influenced predominantly by Western culture and values. Autonomy is accepted as a value particularly within Western cultures but it needs to be acknowledged that not all cultures give it similar status. A study of nurses working in cultural settings where autonomy is not given similar standing is recommended to determine what similarities and differences exist in the processes used by those nurses when personal values and beliefs are challenged.

Only a limited number of studies have investigated how nurses actually determine they are being ethically challenged. The current study identified that the nurses often knew they were being personally challenged by an ethical situation because they felt uncomfortable, using descriptors indicating physical or emotional discomfort. This identified the embodied nature of self-awareness nurses often use to know they have encountered an ethical problem. Although there were a few studies related to ethical challenges that concurred with these findings, there were no studies identified which primarily focused on investigating how nurses determined for themselves that their personal values and belief systems are being challenged. Additionally, a limited number of studies indicate nurses fail at times to identify the ethical issues in challenging situations. There is a need to further explore how nurses know they are being ethically challenged, and a need to further investigate the embodied nature of self-awareness in such circumstances.

Conclusion

This thesis embodies the findings of a research study in which I have investigated the psychosocial processes used by registered nurses when they encounter ethical situations in their work that challenge their personal values and

belief systems. The data collected have been used to develop a substantive theory that describes and explains a pattern of reasoning which gives priority to client autonomy. The core category in the theory is *protecting client autonomy,* a value which takes priority as nurses reason through situations which personally challenge them.

Initially the process commences with recognition that personal values and beliefs are being challenged, and this usually involves an embodied sense of physical or emotional responses to the challenge. In order for this to occur, nurses need to be self-aware about what their personal values and beliefs are and what has influenced them. A process of determining duties to other/s versus self then takes place, with nurses who give priority to client autonomy willingly positioning the client as decision-maker. In so doing, they consider the moral responsibilities they have to self, but avoid imposing their preferences on the client, unless there are values or beliefs involved which they are unwilling to compromise. Nurses then engage themselves as protectors of client autonomy, at times being prepared to take risks to do so, although there are occasions when they have to yield to constraints. Protecting client autonomy does at times result in positive outcomes for nurses. However, there are times when the consequences for them are emotionally difficult, resulting in tension or anguish. Further, even when the outcome is satisfactory, the energy expended to obtain such a result can be emotionally taxing. Appropriate support systems need to be available to nurses to assist them to restore from tension or anguish. Nurses may also make personal and professional changes to assist them in dealing with ethical tension and anguish and such changes need to link back to self-awareness.

The results of this study indicate that nurses who experience challenges to their personal values and beliefs use a process which gives priority to protecting client autonomy. This indicates a paradox because they highly value autonomy, but willingly relinquish their own in order to protect the autonomy of clients, unless they consider they are prevented from doing so. Although weighting client autonomy so highly may be the result of reasoned and reflective decision-making, it is also evident that some nurses resort to it as an easy option in ethically problematic situations. Irrespective of which of these possibilities motivates the protection of client autonomy, the personal consequences of this pattern of moral reasoning have

important implications for nurses themselves and for the nursing profession. Nurses who choose to respect the autonomous rights of their clients need to be able to do so in an environment where respect for their own autonomy is also clearly evident. They need to know that their opinions, based on personal values and beliefs matter, even if they choose not to impose them on others.

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Appendices
Appendix I

Gwen Wilkinson
PhD (Nursing) Student

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INFORMATION FOR DIRECTORS OF GRADUATE TRANSITION PROGRAMS

"The experience of newly registered nurses when faced with ethical situations that challenge their personal values and belief systems"

My name is Gwen Wilkinson and I am currently enrolled in PhD studies with the Faculty of Nursing at the University of Newcastle, under the supervision of Professor Irena Madjar and Associate Professor Margaret McEniery.

In this study I am investigating decision-making processes used by newly registered nurses when they are faced with ethical issues in the clinical setting that challenge their personal values and belief systems. I am seeking your help to facilitate the process of recruiting suitable participants for the study.

The eligibility criteria for inclusion in this study includes that participants be:

1. newly registered nurses (up to 2 years since completion of a Bachelor of Nursing degree, completed in Australia);
2. currently registered with the NSW Nurses Registration Board;

I am seeking your assistance to distribute letters of introduction (see attached) describing the study to newly employed registered nurses in your area health service (or hospital). I hope to recruit at least 10 nurses who meet the above criteria from your hospital/area health service. The attached letter indicates that anyone who is interested in participating in the study can contact me directly for an information package. All that I am asking you to do is to distribute the introduction letter to nurses likely to meet the criteria for inclusion in the study.

I would be happy to meet with any group of potential participants, at their invitation and convenience, if they would like to meet me in person, or have me explain any aspects of the study to them. If convenient to you, such a meeting could be scheduled during an orientation or education day and should not take more than 15-20 minutes.

If you have any questions regarding this procedure or the study itself, please contact me in any of the following ways:

Telephone:	(02) 4980 2223
E-mail:	gwen.wilkinson@avondale.edu.au
Postal address:	Gwen Wilkinson
	Faculty of Nursing
	Avondale College
	Cooranbong, NSW, 2265

Thank you for your consideration of this request.

Yours sincerely

_____   _____
Ms Gwen Wilkinson   Professor Irena Madjar
Researcher   Research Supervisor

Appendix II

Gwen Wilkinson
PhD (Nursing) Student

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INFORMATION SHEET FOR POTENTIAL PARTICIPANTS
IN THE STUDY ON

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

My name is Gwen Wilkinson and I am currently enrolled in PhD studies with the Faculty of Nursing at the University of Newcastle, under the supervision of Professor Irena Madjar and Associate Professor Margaret McEniery.

Thank you for your interest in the research project in which I am investigating decision-making processes used by registered nurses when they are faced with ethical issues in the clinical setting that challenge their values or personal belief systems. I plan to include around 30 nurses in the study from a number of locations in NSW.

If you agree to be part of the study, I will ask you to:
- take part in one face-to-face interview, lasting approximately 30 minutes to one hour at a place convenient to you, and
- provide written comments on a clinical scenario (vignette) that will be provided to you at the end of the interview.

You will be free to read the vignette and complete your responses in your own time, but I would ask you to return your comments in the stamped and addressed envelope provided within 2 weeks of the interview.

With your agreement, the interview will be audio-taped for transcription at a later date. If during the interview you make any comments that you do not wish to be recorded, the tape recorder will be stopped, or if already recorded, the comments will be erased before continuing the interview. You will also be given the opportunity to review the written transcript of your interview and will be free to delete, add, or change anything that you said during the interview.

The interview will focus on asking you to: (1) provide an overview of your personal values and/or belief system; (2) identify one or more clinical situations you have faced in your work as a registered nurse that have challenged your personal values or belief system (i.e. the beliefs and principles that you use when deciding how to act in an ethically challenging situation); and (3) discuss how you have dealt with this challenge. At the end of the interview, I will ask you to provide me with some basic demographic information, including your age, previous work experience, , the institution where you completed your nursing

degree, time since completion, and the types of clinical settings in which you have worked since graduation.

At the conclusion of the face-to-face interview you will be given a copy of a short clinical vignette to take with you. I would like you to read the vignette and then make written responses to attached questions. A stamped, addressed envelope will be provided to allow you to post these responses back to me. A degree of anonymity will be provided in this part of the study since you will not be required to include your name with your response, and no attempt will be made to link specific responses with individual nurses.

If you agree to participate we will negotiate a mutually convenient time and place for the interview. Opportunity will be given for you to ask any questions you have about the study, and you will then be asked to sign a consent form indicating your willingness to be a participant.

I will also ask for 6-8 volunteers from among the nurses who take part in the interviews to meet with me individually again at a later date (possibly 6-12 months later). This meeting will be used to discuss the findings of the study and to obtain feedback on my preliminary interpretations. It will not involve another interview, and will not ask for new data from the nurses who agree to take part.

All data gathered from you will be treated with confidentiality and used only for the purposes of this study. Participants will not be identified in any way in the research report, or in any subsequent publications that may develop from the findings of the study. Pseudonyms will be used in any published work.

- If you agree to take part in this study, you are reminded that you have the right to:

  1. ask questions about the study at any time, and to seek information about the results on completion;
  2. view any written notes made during the interview;
  3. decline to answer any questions during the interview, or to ask for the tape recorder to be turned off, or a portion of the tape to be erased;
  4. terminate the interview, or re-schedule it if necessary; and
  5. withdraw from the study at any time, without having to provide a reason.

- This study has no connection with your current employment status.

- You may find taking part in the study personally helpful, particularly as it gives you an opportunity to reflect on ethically challenging situations you have had to face in the clinical area. However, there is a possibility that you may experience some emotional discomfort, or even distress, as you reflect on such situations. You need to also be aware that should you reveal any details of specific incidents that are of a reportable nature the researcher has a responsibility to report such to the appropriate authorities. You are reminded that you have complete control over the information you decide to share during the interview.

- The audio-tapes and any notes from the interviews, the transcripts of the audio tapes, and the written responses will be kept in a secure place, and be accessed only by myself, although you will be offered the opportunity to read your own transcript for accuracy and modification if you wish. The only other individuals who will have access to the transcripts and written responses (for supervisory reasons alone) are my two research supervisors, but they will not know your identity. When the study is completed, the tapes will be erased. The transcripts and other written material collected during the study (with

all identifying information removed) will be stored in a secure place at the University of Newcastle for the mandated period of five years, following which they will be destroyed.

If you are willing to take part in this study, please complete the enclosed form and post it in the stamped, addressed envelope provided.

If you have any questions regarding this study please feel free to contact me by one of the following methods:

Telephone:	(02) 4980 2223
E-mail:	gwen.wilkinson@avondale.edu.au
Postal address:	Gwen Wilkinson
	PO Box 19
	Cooranbong NSW 2265

Thank you for your interest in this project.

_____   _____
Ms Gwen Wilkinson   Professor Irena Madjar
Researcher   Research Supervisor

Complaints
This project has been approved by the University's Human Research Ethics Committee, Approval No. H-015-1200, and the XX Area Research Ethics Committee of XX Health, Reference 00/12/13/3.29.

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au, or to XX (name not disclosed in thesis to maintain anonymity) Area Research Ethics Committee, XX Health, …, telephone …, email …

Appendix III

Gwen Wilkinson
PhD (Nursing) Student
Tel: (02) 4980 2223
E-mail: gwen.wilkinson@avondale.edu.au

Supervisors: Professor Irena Madjar
& Associate Professor Margaret McEniery
School of Nursing and Midwifery
Faculty of Health
The University of Newcastle
Tel: (02) 49217043
Fax: (02) 4921 7069

INFORMATION SHEET FOR POTENTIAL PARTICIPANTS
IN THE STUDY ON

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

My name is Gwen Wilkinson and I am currently enrolled in PhD studies with the Faculty of Nursing at the University of Newcastle, under the supervision of Professor Irena Madjar and Associate Professor Margaret McEniery.

Thank you for your interest in the research project in which I am investigating decision-making processes used by registered nurses when they are faced with ethical issues in the clinical setting that challenge their values or personal belief systems. I plan to include around 30 nurses in the study from a number of locations in NSW.

If you agree to be part of the study, I will ask you to:

- take part in one face-to-face interview, lasting approximately 30 minutes to one hour one hour at a place convenient to you, and
- provide written comments on a clinical scenario (vignette) that will be provided to you at the end of the interview.

You will be free to read the vignette and complete your responses in your own time, but I would ask you to return your comments in the stamped and addressed envelope provided within 2 weeks of the interview.

With your agreement, the interview will be audio-taped for transcription at a later date. If during the interview you inadvertently name any person or make any comments that you do not wish to be recorded, the tape recorder will be stopped, or if already recorded, the comments will be erased before continuing the interview. You will also be given the opportunity to review the written transcript of your interview and will be free to delete, add, or change anything that you said during the interview.

The interview will focus on asking you to: (1) provide an overview of your personal values and/or belief system; (2) identify one or more clinical situations you have faced in your work as a registered nurse that have challenged your personal values or belief system (i.e. the beliefs and principles that you use when deciding how to act in an ethically challenging situation); and (3) discuss how you have dealt with this challenge. At the end of the

interview, I will ask you to provide me with some basic demographic information, including your age, previous work experience, the institution where you completed your nursing degree, time since completion, and the types of clinical settings in which you have worked since graduation.

At the conclusion of the face-to-face interview you will be given a copy of a short clinical vignette to take with you. I would like you to read the vignette and then make written responses to attached questions. A stamped, addressed envelope will be provided to allow you to post these responses back to me. A degree of anonymity will be provided in this part of the study since you will not be required to include your name with your response, and no attempt will be made to link specific responses with individual nurses.

If you agree to participate we will negotiate a mutually convenient time and place for the interview. Opportunity will be given for you to ask any questions you have about the study, and you will then be asked to sign a consent form indicating your willingness to be a participant.

I will also ask for 6-8 volunteers from among the nurses who take part in the interviews to meet with me individually again at a later date (possibly 6-12 months later). This meeting will be used to discuss the findings of the study and to obtain feedback on my preliminary interpretations. It will not involve another interview, and will not ask for new data from the nurses who agree to take part.

All data gathered from you will be treated with confidentiality and used only for the purposes of this study. Participants will not be identified in any way in the research report, or in any subsequent publications that may develop from the findings of the study. Pseudonyms will be used in any published work.

- If you agree to take part in this study, you are reminded that you have the right to:

    1. ask questions about the study at any time, and to seek information about the results on completion;
    2. view any written notes made during the interview;
    3. decline to answer any questions during the interview, or to ask for the tape recorder to be turned off, or a portion of the tape to be erased;
    4. terminate the interview, or re-schedule it if necessary; and
    5. withdraw from the study at any time, without having to provide a reason.

- This study has no connection with your current employment status.

- You may find taking part in the study personally helpful, particularly as it gives you an opportunity to reflect on ethically challenging situations you have had to face in the clinical area. However, there is a possibility that you may experience some emotional discomfort, or even distress, as you reflect on such situations. You need to also be aware that should you reveal any details of specific incidents that are of a reportable nature the researcher has a responsibility to report such to the appropriate authorities. You are reminded that you have complete control over the information you decide to share during the interview. You are also advised that it may not be in your interest to disclose any information that may have legal implications.

- The audio-tapes and any notes from the interviews, the transcripts of the audio tapes, and the written responses will be kept in a secure place, and be accessed only by myself, although you will be offered the opportunity to read your own transcript for accuracy and modification if you wish. The only other individuals who will have access to the

transcripts and written responses (for supervisory reasons alone) are my two research supervisors, but they will not know your identity. When the study is completed, the tapes will be erased and any handwritten responses destroyed. The transcripts of interviews and written material collected during the study (with all identifying information removed) will be stored in a secure place at the University of Newcastle for the mandated period of five years, following which they will be destroyed.

If you are willing to take part in this study, please complete the enclosed form and post it in the stamped, addressed envelope provided.

If you have any questions regarding this study please feel free to contact me by one of the following methods:

Telephone:	(02) 4980 2223
E-mail:	gwen.wilkinson@avondale.edu.au
Postal address:	Gwen Wilkinson
	PO Box 19
	Cooranbong NSW 2265

Thank you for your interest in this project.

_____   _____
Ms Gwen Wilkinson   Professor Irena Madjar
Researcher   Research Supervisor

Complaints
This project has been approved by the University's Human Research Ethics Committee, Approval No. H-015-1200, and the YY Health Ethics Committee, Reference 14/03/2001.

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au, or to The Secretary, YY (name not disclosed in thesis to maintain anonymity) Health Ethics Committee, YY Area Health Service…, telephone …

Appendix IV

Gwen Wilkinson
PhD (Nursing) Student

Tel: (02) 4980 2223
E-mail: gwen.wilkinson@avondale.edu.au

Supervisors: Professor Irena Madjar
& Associate Professor Margaret McEniery
School of Nursing and Midwifery
Faculty of Health
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Tel: (02) 49217043
Fax: (02) 4921 7069

INDICATION OF INTENTION TO PARTICIPATE IN THE STUDY

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

I, (**please print name**) _____ am interested in participating in the above named study. I give my permission for you to contact me to organise an appointment for an interview at a time and place that is suitable to me.

I can be contacted by:

(Please write in the information that applies to you, and indicate your preference)

Phone: _____

Email: _____

Post to: Gwen Wilkinson
          PO Box 19
          Cooranbong NSW 2265

                    or

Email: gwen.wilkinson@avondale.edu.au

Appendix V

Gwen Wilkinson
PhD (Nursing) Student

Tel: (02) 4980 2223
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Faculty of Health
The University of Newcastle
Tel: (02) 49217043
Fax: (02) 4921 7069

CONSENT FORM FOR PARTICIPANTS

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

I, (**please print name**) _____ agree to participate in the above named study to be conducted by Ms Gwen Wilkinson, and I give my consent freely.

I understand the study will be carried out as described in the information statement, a copy of which I have retained. I understand that whether or not I decide to participate my decision will not affect my current employment in any way. I also understand that I can withdraw from the study at any time and do not have to give any reasons for withdrawing. I understand that all information I provide will be treated in confidence. I have had all questions answered to my satisfaction.

Participant's Signature …………………………………..

Date ……………………

Appendix VI

Gwen Wilkinson
PhD (Nursing) Student

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Supervisors: Professor Irena Madjar
& Associate Professor Margaret McEniery
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Faculty of Health
The University of Newcastle
Tel: (02) 49217043
Fax: (02) 4921 7069

CONSENT FORM FOR PARTICIPANTS

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

I, (**please print name**) _____ agree to participate in the above named study to be conducted by Ms Gwen Wilkinson, and I give my consent freely.

I understand the study will be carried out as described in the information statement, a copy of which I have read and retained. I understand that whether or not I decide to participate my decision will not affect my current employment in any way. I also understand that I can withdraw from the study at any time and do not have to give any reasons for withdrawing. I understand that all information I provide will be treated in confidence. I have had all questions answered to my satisfaction.

I am aware that, should I reveal any details of specific incidents that are of a reportable nature, the researcher has a responsibility to report such to the appropriate authorities. I am aware that I have complete control over the information I decide to share during the interview. I am also aware that it may not be in my interest to disclose information that may have legal implications.

It has been explained to me that the research project will be carried out according to the principles in the National Health and Medical Research Council Statement on Ethical Conduct in Research Involving Humans (1999) and has been approved by the YY (name not included in thesis to maintain anonymity) Ethics and Research Committee.

Participant's Signature …………………………………..Date …………………….

Signature of Witness ……………………………..   Date …………………..

Appendix VII

INTERVIEW SCHEDULE

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

Prior to the commencement of the interview, the details of the study, as outlined on the information letter, will be reiterated to ensure that participants understand the intention of the study and their rights as research participants. They will then be requested to sign the consent form.

Measures will be taken to conduct the interview in a way that minimises any emotional discomfort that might occur as participants discuss issues related to the topic of the study. An informal interview environment will be maintained and questions will be asked in a non-confrontational way, using a friendly, collegial demeanour. If any signs of distress do occur, the interview will be stopped temporarily, and if necessary, rescheduled for another time.

At the commencement of the interview participants will be encouraged to share information in a way that maintains anonymity and confidentiality and will be reminded that:
1.   they have complete control over what they disclose;
2.   the tape recorder can be stopped at any time if they do not wish some information to be recorded;
3.   portions of the tape can be erased to remove any statements they do not wish to remain recorded;
4.   in reference to any third parties they should: (i) not use any actual names of persons or institutions; (ii) not identify the time or place of the event in specific terms; and (iii) not reveal any other identifying details (such as the social prominence of a patient);
5.   opportunity will be provided for them to review their interview transcripts and edit, delete, or add information as they see fit.

INTERVIEW QUESTIONS

What is it about nursing, as you have experienced it so far in your career, that makes ethics relevant and important to nursing work?
(Why do you think we need to consider ethical issues in our practice?
 How do nurses help patients and themselves to deal with difficult decisions?
 Is scientific or clinical knowledge enough, or do we need other kinds of knowledge?)

Have you come across any situations in your work so far that have resulted in an ethical dilemma or conflict, either for you personally or for others?
(Can you give me an example of such a situation?
 What or who contributed to the dilemma or conflict?
 What do you see as a difference between a clinical dilemma and an ethical dilemma?)

It is generally assumed that all people hold some kind of beliefs and values that are important to them. Can you share with me some of the values, or principles, or beliefs that are important to you?
(How much of these values and/or beliefs has come to you through your family upbringing?
 What has led you to personally embrace these values or beliefs as an adult person?
Are there any significant life events that have influenced the values or beliefs you   hold?

Do you see your personal values and beliefs as fitting within a particular religious or philosophical framework?)

Can you describe for me how you would think through the issues when faced with a moral or ethical decision in your practice as a nurse?
(You may like to think of a specific situation, or discuss this question in general terms.
What would be uppermost in your mind?
Are there any principles or rules that you would use?
Would there be any specific values that you would be committed to maintaining? How would you determine which value/s should take priority?
Would you talk to others in the process of making your decision? Who would be the most likely person you would consult?)

Are there any particular situations or events you have faced as a registered nurse that have challenged your personal values or beliefs?
(Can you describe for me your involvement in a situation that challenged your personal values or beliefs? What happened?
Who else was involved?
What aspects of the situation did you find morally challenging?
How did you feel in the midst of this situation?)

How did you deal with this challenge?
(How did you participate or not participate in what was happening? What part, if any, did you play in dealing with the situation?
How much power or influence did you feel that you had?
How well were you able to express your views?
How much support did you receive from your colleagues?
What was the eventual outcome of the situation?
What was the outcome for you personally? How did/do you feel about it?
What did you learn as a result of that experience?)

Can you suggest strategies that might help other nurses deal with situations that challenge their personal values or beliefs in the clinical setting?
(What, if anything, would you have liked to see done differently from the way the incident you shared with me was dealt with?
 What do you think would have helped you personally when you faced that situation?
 Have you observed other nurses, or discussed with them how they have dealt with similarly challenging situations?)

Appendix VIII

Gwen Wilkinson
PhD (Nursing) Student

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E-mail: gwen.wilkinson@avondale.edu.au

Supervisors: Professor Irena Madjar
& Associate Professor Margaret McEniery
School of Nursing and Midwifery
Faculty of Health
The University of Newcastle
Tel: (02) 49217043
Fax: (02) 4921 7069

DEMOGRAPHIC QUESTIONNAIRE FOR PARTICIPANTS

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

1. Age? _____ years

2. Gender?   Male   Female

3. At what institution/s did you complete your nursing qualification/s?

4. How long is it since you completed your initial nursing qualification? _____
   years

5. List the types of clinical settings in which you have worked since completing your nursing qualification.

6. Did you have any previous work experience prior to nursing?   Yes   No
   If you answered yes, please identify what it was

Appendix IX

Further Contacts

If, on reflection, you wish to follow through on any issues raised in the interview it may be helpful to you to have the following list:

The St James Ethics Centre: This centre is a non-profit, non-political organisation that has a helpline which provides a confidential counselling service. It aims to help people who contact them to deal with ethical dilemmas they have confronted in the workplace. The researcher has permission from the Centre to provide information about their service to participants.

The Nurses Registration Board, New South Wales (NSW): The Nurses Registration Board has a process whereby any individual can lodge a complaint in relation to the professional conduct of an accredited nurse. Such complaints, which must be submitted in writing, are dealt with in consultation with the Health Care Complaints Commission.

The Health Care Complaints Commission: Although established by the NSW Parliament, this is an independent statutory body with a commitment to promote the rights of NSW health consumers. Any individual, including health care service providers such as nurses, has the right to lodge a complaint with the commission.

Appendix X

Gwen Wilkinson
PhD (Nursing) Student

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Supervisors: Professor Irena Madjar
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"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

CLINICAL VIGNETTE 1

Please read the following clinical scenario and answer the questions that follow.
Please do not include your name or any other identifying details in your responses.

Scenario
A registered nurse (Nurse A), with six months post-graduate experience, works for a nursing agency and accepts a job to work a shift in a gynaecological ward of a public hospital. The nurse is assigned to prepare a patient for termination of pregnancy scheduled to occur later that morning. The patient is 18 weeks pregnant and has made the decision to terminate the pregnancy based on the results of amniocentesis tests that indicate the foetus to have Down syndrome.

On finding out the details of the case, Nurse A approaches the Nursing Unit Manager (NUM) and requests that the allocation of that particular patient be changed because the reason given for the termination of pregnancy in this particular case contravenes Nurse A's personal beliefs. Nurse A points out that the request is out of concern for the patient who may not be provided with adequate emotional care and support that she clearly needs at this critical time.

At this point, another nurse on the ward (Nurse B), who has several years of clinical experience, offers to change patient assignment with Nurse A to help resolve the situation. The NUM, however, remains adamant that the initial allocations are to be maintained because Nurse B's expertise is required for the care of the seriously ill patients in the ward.

Nurse A walks away from the discussion complaining of feeling ill. Nurse A returns to the NUM's office a few minutes later and cites a stress-induced migraine as the reason for not being able to continue working that day.

Questions:

1. If you were in Nurse A's position in this situation, how would you have responded? (As Nurse A did, or differently? Please comment.)

2. What personal values or beliefs would influence your decisions and actions in this situation?

3. Do you consider that Nurse A was ethically justified in asking for a change in patient assignment? If yes, please explain why you believe that Nurse A was justified. If not, please explain why you believe that Nurse A was not justified.

4. If you were in Nurse B's position, how would you have responded? (As Nurse B did, or differently? Please comment.)

5. Do you believe the NUM acted ethically in refusing to allocate the patient to Nurse B? If yes, please explain why you believe that the NUM acted ethically. If not, please explain why you believe that the NUM did not act ethically.

6. What ethical issues, if any, do you see in Nurse A's actions in leaving work?

7. Have you ever asked not to be allocated to care for a particular patient because involvement in their care would have compromised your values or personal belief system? If yes, please describe what happened

8. Conversely, have you ever offered (or been asked) to care for a particular patient because another nurse has requested not to be involved in this patient's care? If yes, please describe what happened.

9. Can you envisage clinical situation(s) in which you would be prepared to compromise your own personal beliefs in order to provide professional care to a patient? If yes, please describe a situation and your reasons for choosing to act in a particular way.

When completed, please post to:

Gwen Wilkinson
PO Box 19
Cooranbong NSW 2265

Appendix XI

Gwen Wilkinson
PhD (Nursing) Student

Tel: (02) 4980 2223
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Tel: (02) 49217043
Fax: (02) 4921 7069

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

CLINICAL VIGNETTE 2

Please read the following clinical scenario and answer the questions that follow. Please do not include your name or any other identifying details in your responses.

Scenario
Mr X, an 85-year-old widower who has been living independently, suffers a stroke at home. He is found several hours later by a friend and is admitted to an acute care hospital. Initial therapy includes rehydration with intravenous fluids and the insertion of an indwelling urinary catheter. The stroke has seriously affected Mr X's swallowing and speech. Simple forms of signing and the use of an alphabet board are implemented to aid communication.

Four days after the stroke his doctor decides that a nasogastric tube is required to provide nutrition, as the patient is starting to lose weight. The doctor explains the necessity for nasogastric feeding to Mr X. When nurse Y (a newly registered nurse with six months experience), who has been assigned to care for Mr X, prepares to insert the tube he becomes very agitated and indicates that he does not want the tube put in. Nurse Y repeats the explanation for nasogastric feeding provided earlier by the doctor, but the patient indicates his unwillingness to allow the tube to be inserted. Using the alphabet board, he communicates that given his recent stroke and his quality of life, he just wants to be allowed to die. Nurse Y reports this to the Nursing Unit Manager (NUM) who contacts the doctor. The doctor agrees that they should not insert the tube at this stage.

The next day Mr X has another stroke and lapses into a coma. Two hours later Mr X's daughter and her husband arrive from interstate. They tell the nursing and medical staff that they would like all measures used to maintain Mr X's life, no matter what the cost. In spite of the patient's earlier refusal, the doctor now orders the insertion of the nasogastric tube. Because of his previous response to the procedure, Nurse Y, who is caring for him again, refuses to insert the tube. Citing the urgency of the situation, the NUM takes over Mr X's care and inserts the tube.

The following day, with no signs of improvement in the patient's condition, the doctor meets with the family and indicates that further interventions are likely to be futile. The doctor seeks their views on cardio pulmonary resuscitation (CPR), indicating that CPR may become necessary and would have to be implemented unless the family provide a clear directive that CPR should not be attempted. Mr X's daughter (his next of kin) insists that "all possible treatment should continue and every attempt made to save Mr X's life". Nurse Y is distressed about this and, after the family has left, points out to the doctor that Mr X expressed very clearly his wish to be allowed to die. The doctor's response is that because there is no clear statement by Mr X actually refusing CPR, the wishes of the next of kin will have to be respected.

Questions:

1. If you were in Nurse Y's position in this situation, how would you have responded? (As Nurse Y did, or differently? Please comment.)

2. What personal values or beliefs would influence your decisions and actions in this situation?

3. Do you consider that Nurse Y was ethically justified in refusing to insert the nasogastric tube? If yes, please explain why you believe that Nurse Y was justified. If not, please explain why you believe that Nurse Y was not justified.

4. Do you consider that the NUM was ethically justified in taking over Mr X's care and inserting the nasogastric tube? If yes, please explain why you believe that the NUM was justified. If not, please explain why you believe that the NUM was not justified.

5. What ethical issues, if any, are involved in hospital staff giving treatment that the patient has apparently refused?

6. What do you consider to be the ethical issues in Mr X's family making decisions about his ongoing care?

7. What do you consider to be the ethical issues involved in providing acute hospital care in an apparently futile attempt to maintain Mr X's life?

8. Have you ever refused to implement a treatment for a particular patient because doing so would have compromised your values or personal belief system? If yes, please describe what happened.

9. Conversely, have you ever offered (or been asked) to perform a treatment for a particular patient because another nurse has requested not to do it? If yes, please describe what happened.

10. Can you envisage clinical situation(s) in which you would be prepared to compromise your own personal beliefs in order to provide professional care to a patient? If yes, please describe a situation and your reasons for choosing to act in a particular way.

When completed, please post to:

Gwen Wilkinson
PO Box 19
Cooranbong NSW 2265

Appendix XII

Gwen Wilkinson
PhD (Nursing) Student

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E-mail: gwen.wilkinson@avondale.edu.au

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Faculty of Health
The University of Newcastle
Tel: (02) 49217043
Fax: (02) 4921 7069

FOLLOW-UP LETTER TO PARTICIPANTS

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

Dear Colleagues

I would like to thank you very much for your participation in my study and the time you have given to it. If you have also returned your written response to the clinical vignette, I would like to thank you for this extra time and effort.

If, however, you have not yet responded to the clinical vignette, it is not too late. If you are willing to do it, I would ask you to return your response within the next two weeks. The information you send will provide important data for my study.

Thank you. I greatly value your contribution.

_____

Ms Gwen Wilkinson
Researcher

Appendix XIII

Gwen Wilkinson
PhD (Nursing) Student

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TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

I, (**please print name**) _____ have agreed to transcribe audio tapes of research interviews carried out by Gwen Wilkinson for the above named study. I understand that the information on the tapes is confidential and I agree to take all steps necessary to ensure that:

1. the audio tapes are heard only by me;
2. the audio tapes and the transcribed material (both computer copies and paper copies) are stored in a secure place until they are returned to the researcher;
3. any computer copies not returned to the researcher are immediately erased; and
4. all information pertaining to the interviews is kept confidential.

Signature …………………………………..   Date …………………….

Appendix XIV

List of Categories During Analysis

NVivo revision 2.0.161   Licensee: Gwen Wilkinson

Project: Ethics and values 1 2 User: Administrator   Date: 16/01/2004 - 10:23:21 AM

NODE LISTING

Nodes in Set: All Free Nodes
Created: 12/01/2004 - 5:08:37 PM
Modified: 12/01/2004 - 5:08:37 PM
Number of Nodes: 20
1   black and white
2   causes of conflict/challenges
3   change over time
4   currently uncoded
5   decision-making process
6   ethical values
7   frequency of conflicts
8   importance of ethics
9   influences on value system
10   lack of support
11   legal implications
12   new registered nurse
13   outcome
14   personal and professional link
15   power to make decisions
16   questioned staying in nursing
17   reactions to challenges
18   role of a nurse
19   strategies
20   supported

Appendix XV

CATEGORY: PERSONAL AND PROFESSIONAL LINK

This category describes a connection that is apparent between the personal values, beliefs, or experiences of the participant and their professional situation or experience, and vice versa.

Participant X
- Developed my own sense of ethics over last 20 years through the way I've lived my life
- I have a religious, philosophical belief system but I separate that from my work practice

Participant X
- Your culture is already challenged so there's clashing with your practice
- As you mature your view changes

Participant X
- My nursing has a huge amount to do with the values I embrace
- Not just nursing but my own personal experiences show me what's right for one person is not going to be right for another
- This ethos was a really big part of our upbringing

Participant X
- Very authoritarian schooling made me think people's independence was important
- I had a religious upbringing and that caring side of religious instruction struck
- There's a lot of nursing in my family

Participant X
- Clinically you have to act so you do separate personal and professional decisions
- I believe my religious upbringing is deeply entrenched in my belief system
- As I grow older I question religion and God
- Times are changing and I've changed too

Participant X
- I think they link
- What I portray in my professional life is not different
- It's very hard to separate and have one set for professional and set for personal - I don't
- Values develop from a mixture of everything
- Being older has helped me because I'm a lot more prepared to stand up for what I believe is right and wrong
- Age and my life experience give me competence

Participant X

- I come from a strict Catholic upbringing
- Looking at people as individuals has taken me a long time
- They're the sort of things that are most important for me as a nurse and as a person too
- Separating private and professional decision-making is how I survive
- If feeling uncomfortable I have to look at upbringing and think that's where it's coming from
- I don't tell certain family members what I do at work

Participant X
- Personal firsthand experience is beneficial to professional life
- Need to utilise the link between personal and professional
- You have to clarify your own bias and ethics and see how you can integrate that for the good of nursing

Participant X
- I keep them [personal and professional values] the same all the way through I don't think you should be Jekyll and then over here be someone else

Participant X
- I can't separate them because they're me
- It's therapeutic use of self
- With some things I'm a bit more tolerant at work
- Started nursing in 30s so had a whole heap of prior life experience
- Had well developed way of looking at things in conflict situations

Participant X
- Things develop and change
- I have different values about people than I have from my family
- That's due to changes in my journey as an adult
- It's taken me a long time to get rid of those and start to see the world in a different way
- It takes a long time and I think it's experiences you have
- Some is my profession but a lot more has changed in my personal life
- I take that to my profession
- You can be aware of both but who I am as a nurse is part of who I am as a person and I don't believe you can separate the two
- I would argue that if people say that their personal values aren't reflected in what they do that perhaps they're fooling themselves
- I don't think you can have separate nursing values and separate personal values
- That's a value I learnt through professional experience
- A lot of who I am as a person has also come from nursing
- So many things I decide on today are an accumulation of the experiences I've had as a person and as a nurse

Participant X
- Values are something you grow up with
- Nursing brings certain things to your attention

- Basic ethics (about doing the right thing) is something you bring with you
- Whatever you're doing your personal values are there
- I don't think you can pretend they're not there
- Professional values may over-ride personal ones
- The fact you've got personal values is what makes you consider whether they should over-run you
- Values haven't changed – just more aware of them
- Values don't change – the way you implement or express them may
- Values are inbuilt
- Core being of you as a person is there, wherever
- Nursing has influenced but values are there to start with
- Professional view over-rode what personally felt

Participant X
- Don't let personal view get in the way of patient's needs
- None of my business why a woman chooses to have a termination
- Don't express my view unless specifically asked
- Not the time/place to have personal views interface with professional conduct
- What I believe about terminations is my business
- Won't let personal beliefs compromise a clinical situation
- May be some things professionally that conflict with personal values
- Personal values have changed and grown
- Changed due to nursing experience and religious experience
- Haven't confronted anything which would compromise my religious beliefs
- Professionally there to look after client
- Nurses need to have themselves sorted out [re belief system] better than the average person

Participant X
- A lot of RNs make decisions based on what they want
- Past experiences impact on you and help develop your values
- Past experiences help mould the person you are
- Values have developed and grown through nursing
- Finding out about self has made a difference to attitudes
- Seen doctors who won't order S8s for dying clients because of religious beliefs

Participant X
- Times when personal values have been in conflict with professional values/expectations
- Can't divorce personal and professional values
- You bring to any situation who you are
- Can't separate yourself from your personal and private life
- May put you in sufficient conflict where you need to ask to be removed from the situation

Participant X

- Nursing has made me re-think some personal values
- Some values have been clarified by nursing
- Some values have been strengthened by nursing
- Nursing has changed some of my attitudes
- Values previous to nursing were based on a blinkered view of the world
- Some values modified but still stayed within Christian belief system
- Every nurse brings their own personality to nursing
- The values I hold have impacted on the way I do my work definitely
- Values determine the type of work I do
- My personal values definitely have an impact on what I do
- You are fooling yourself a bit if you think you can have 2 totally separate lives
- Your under-riding value system has to flow through
- Can't have 2 sets of values for different settings

Participant X
- We may not necessarily agree with it but we still have compassion for the person that's going through this and has decided this
- Wouldn't necessarily have an abortion myself but I saw someone else and I refused to put my values on to her
- They're not necessarily enforcing their values on other people
- At the same time I don't necessarily think that I'm separating my values either
- I think I'm pretty well the same to anyone and everyone, what you see is what you get
- I can separate myself enough to never allow that sort of thing to happen [affect patient care] and try not to affect my general work performance

Participant X
- Nursing seemed so arbitrary, unkind and cruel, I was quite horrified
- Midwifery saved me, mended it all back and put it all back together
- I see it [personal and professional] as indivisible

Participant X
- Ethics comes from who you are and what your experiences are and your background
- It comes from where you're at and who you are, probably something that you do without thinking
- When you start nursing you start developing the way you treat people your own particular style
- It's something you are
- I have developed a lot of different thoughts there which are probably very different from when I started nursing
- It's coming from who you are so it has to be you, have to take it with you, you can't leave it behind
- Bring your own personality to nursing

Participant X

- Personally I could think euthanasia's right but because it's illegal I can't let it happen
- You've got those personal values that are conflicting with the values one has to carry out
- Luckily for me they don't conflict, or very rarely

Participant X
- I think I'm the same person at work or at home
- I'm the same person in the job

Participant X
- I have to [separate personal values] otherwise I would be imposing myself on other people
- So there's a great need to be very self-aware [in nursing]
- Nursing has certainly affected personal maturing
- Ethical dilemmas and things can impact you [so] you learn how better to self-care
- Difference between personal values/belief and what see happening can impinge health and personal life

Participant X
- I'd say there are times I have to separate
- I have to separate my belief system to be able to work
- I can't impose that belief on someone else
- I cope with it with saying well God you know
- I do the best I can but I just have to let God's will be done
- I don't have to answer to God about this situation I have to answer to God about whether I do my best

Appendix XVI

Descriptive Story

The nurses have worked in a variety of clinical areas and all have shared scenarios of times when they felt personally challenged by situations in their professional setting. I am interested in knowing how they have dealt with these situations that have challenged their personal value and belief systems.

The development of their current values/beliefs has been transitional, over time. Major influences on the development of the values/beliefs came from their upbringing, personal experiences, maturity, and from nursing experiences. Several commented that they had changed from who they were when they commenced nursing in their late teens to who they were now. Some indicated that nursing itself had impacted on their values/beliefs with resulting modification or growth. Others indicated that nursing had impacted on them but in terms of strengthening or solidifying their already existing values/beliefs, or giving them better insight as to what they were.

The participants spoke of the way their personal values/beliefs impact on their professional situation. Many indicated that they cannot separate their personal values from their professional values because they bring who they are to the work arena. However some did indicate that a form of separation of personal values/beliefs has to occur because they believe they should not allow their personal view to get in the way of clients' needs and choices. There was a strong opinion that nurses should not enforce their values on other people so in that sense there does need to be a separation and indeed a necessity to be very self-aware so as to avoid it. They come to accept the interplay between personal values/beliefs and are able to maintain ethical equilibrium in the personal/professional interface unless there is an ethical conflict. Along with this was a strong recognition of the right to autonomy that clients have. In fact the ethical principle of client autonomy seemed to receive priority over other ethical principles with nurses often being prepared to give precedence to this over their own beliefs. Situations exceptional to this are not common and are likely to occur only if client care will not be compromised or if legal issues have to take priority.

Situations in nursing that require a nurse to deal with ethical conflicts are seen as frequent with some participants indicating that it occurs as part or everyday practice. The types of situations that cause such conflict are varied but can be summarised into the following groups:
- Respecting client autonomy
- Standard of treatment/care (medical and nursing)
- End of life decisions
- Nursing/health system management
- Resource allocation

In many of the examples given the cause of the discomfort or conflict was related to concern for the client and his or her needs.

It was very evident from this group of nurses that the primary focus in the performance of their tasks is their clients. This is often what motivates them to decide

to act. In describing the decision-making process used several participants made reference to the fact that the clients' decisions or needs take precedence. Some referred to having an initial gut feeling that alerts them to the fact that they are being personally challenged, or that something isn't right about the situation. None of the participants made reference to using any formal decision-making model. Only one made reference to using formal codes of ethics on the process. In fact it was evident that many of the participants had difficulty actually verbalising the decision –making process used. They were able to identify that the clients were the focus, but could not easily describe how they then set about deciding what to do, although some mentioned that legal implications had to be considered and some mentioned they often consider what they would do if the client was a member of their family.

When challenged by these situations, what did the nurses do? A variety of activities was indicated depending, on the situation, but they tend to fall in to 2 main responses.

1. At times the nurses made a decision to compromise. What was compromised? - their own values/beliefs. Nurses at times were forced, or chose, to compromise their values/beliefs because of external factors such as legal implications. Nurses at times were prepared to compromise their own values/beliefs in order to give priority to clients' decisions, or because they felt to not do so could cause harm to others (clients, clients' families, colleagues) or self. Sometimes they chose to compromise because they felt they lacked power to do otherwise, one describing it as feeling impotent in the situation. Nurses in this situation need to find some way of dealing with the fact that they've compromised their values/beliefs. How do they do that? Some of them find that over time they actually modify their values/beliefs. Some still hold on to them, but accept that other things at times have to take priority and that they cannot change that. If it gets too difficult some of them change the area in which they work – some even leaving clinical nursing. They may be left with feelings of frustration or anger as a result of the compromise and therefore need strategies to help them deal with these outcomes and thus regain ethical equilibrium. Many of them have found that they have had to implement personal coping strategies rather than having formal strategies available in the work place.

2. At times the nurses made a decision to take a risk – or to put themselves on the line. In situations where this occurred the nurses often had the client's needs as paramount. What were they risking? Depending on the situation they could have risked their reputation or credibility, being ostracised or criticised by colleagues, being ignored, being verbally abused by clients' families, being disciplined, losing their employment, or their health being affected. Again these nurses are often in a situation as a result of acting this way of needing some strategy to deal with the resulting feelings or outcomes, in order to regain ethical equilibrium. As above, many of them have found that they have had to implement personal coping strategies rather than having formal strategies available in the work place.

Both of the responses above require a degree of courage (bravery?) on the part of the nurse. It takes courage to either compromise one's values/beliefs or to take a risk. Why are these nurses prepared to act courageously? The value that they give to client autonomy seems to play an important part in this. They are prepared at times to act

with courage because they accept that is one of the ways they perform their role as a client advocate. Because of the priority they give to their clients' needs/decisions they are at times prepared to compromise or put themselves on the line so that their clients receive appropriate and adequate care. At times they will also have the courage to compromise or put themselves on the line for colleagues, although the instances reported of this happening were not as common.

What are the outcomes/consequences, for the clients, of the nurse acting courageously? In some instances, according to the nurses, the clients' treatment or care was more appropriate or improved. In some instances the clients were empowered to make their own decisions and have them respected. In some instances things did not change for the client but the nurse felt some degree of satisfaction for having tried.

What are the outcomes/consequences, for the nurse, of acting courageously? In some instances the nurse was able to bring about appropriate change and therefore make a difference – in these instances there was a feeling of satisfaction or even pride in bringing about such an outcome. However even in these situations, at times, the nurse had to also deal with negative reactions from colleagues because they did not agree with the way the nurse went about it. Often they had to justify their actions to colleagues and this added to the energy needed to act courageously.

Some nurses shared examples of situations where they either took a risk but were unable to make a difference for the client, or where they were unable, for various reasons, to take a risk. In some of these instances the nurses spoke of still being upset by the incident (even some years later in some circumstances) and at times questioning whether they did the right thing at the time. It seems the outcome for them is still unsatisfactory.

When an individual acts courageously it takes energy and can cause emotional strain on the person. This was often the case for the participants when they were prepared to act courageously when ethically challenged. Many of them shared strategies they use to help them deal with any resulting feelings or strain. For some, they have strategies available in their work places or formal activities that can be beneficial. These include discussion groups or forums, debriefing with colleagues, ethics education, accessing ethics committees, and accessing an Employees Assistance Program, or Chaplain, or Social Worker (depending on work setting). These strategies have the objective of helping the nurse deal with any conflict that may be happening in the personal/professional interface and to help bring back ethical equilibrium. However, many participants complained that there is insufficient support in nursing environments for nurses when they face challenging ethical issues and they highlighted this as an area that needs priority consideration in health care. Many spoke of the advantage of having a forum where discussion could occur in a non-judgemental environment but had found this was not commonly available. This was more likely to be available in environments where there was a lower staff turn-over or less reliance on casual staff, and therefore greater team cohesion.
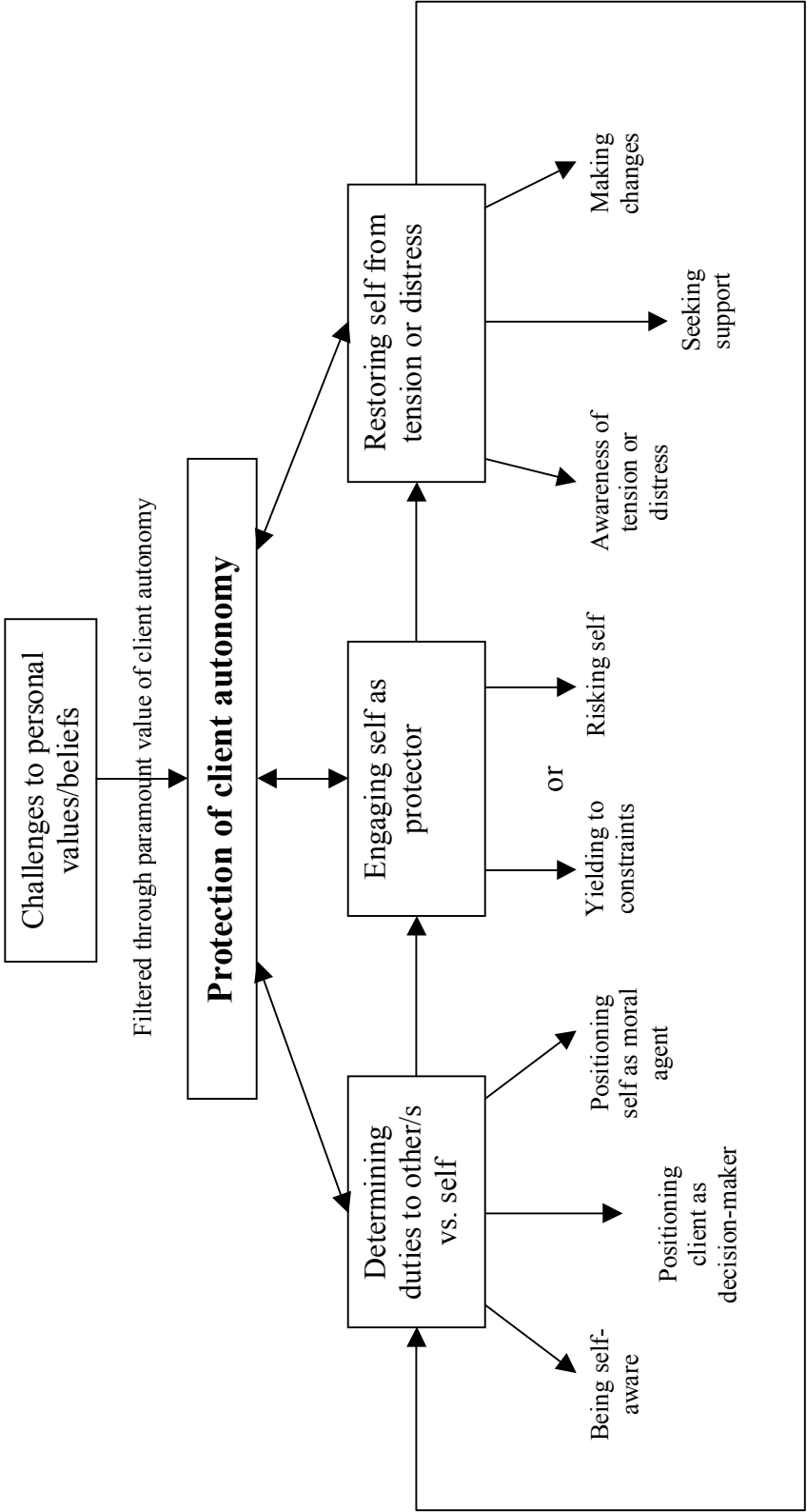
Because of the lack of appropriate strategies in the work place to help nurses deal with the consequences of acting courageously, many of them have developed their

own coping strategies. Some have even actively sought ways to do this in an effort to maintain their ethical equilibrium. These strategies can be quite varied depending on what the individual nurse has found works more effectively for him/her. The skills of reflection, journaling, or finding a trusted confidant (often family member of close friend) to talk with were common personal strategies cited. Additionally indulging in hobbies unrelated to work and making use of one's own spiritual activities were also cited as being beneficial. As one participant put it, she needs personal strategies that are "normalising … [because] my work is really intensely not normal". These strategies also have the objective of helping the nurse deal with any conflict that may be happening in the personal/professional interface and to help bring back ethical equilibrium.

Some participants observed that they knew of nurses who had left the profession because they could not deal with ethical challenges effectively enough to maintain ethical equilibrium. Additionally some cited inappropriate strategies used by some colleagues in an attempt to maintain ethical equilibrium. Short-term effectiveness may be gained by these but there is no guarantee that they will work in the long term.

So if I ask "How do nurses manage clinical situations that are contrary to their personal values/beliefs?" The answer is they do it by giving priority to client autonomy (or what the law says they can do when that has to over-ride). This is an over-simplification, but I need to examine the dynamics of that. How does the process of giving priority to client autonomy actually occur?

Appendix XVII
Early Diagram of Theory

Challenges to personal values/beliefs

Filtered through paramount value of client autonomy

Protection of client autonomy

Determining duties to other/s vs. self

Being self-aware

Positioning client as decision-maker

Positioning self as moral agent

Engaging self as protector

Yielding to constraints

or

Risking self

Restoring self from tension or distress

Awareness of tension or distress

Seeking support

Making changes

Core problem: Ethical challenges to personal values/beliefs

Core Category: Protection of client autonomy

Appendix XVIII
Letter to Participants with Copy of Transcript

<div align="right">

Gwen Wilkinson
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"The experience of registered nurses when faced with ethical situations that challenge their personal values and belief systems"

Dear

Attached is a copy of the transcript of the interview you kindly participated in a few weeks ago as part of my research study. I invite to you check through the transcript to ensure that you are happy with the information it contains. Please don't be concerned with grammar and sentence structure as the way you respond verbally at the time is the important thing. However if you wish to make any modifications to the actual content, particularly in terms of removing or adding information, you are welcome to do so. If you do make modifications you may return them to me by one of the following means:

      Post to: Gwen Wilkinson
                        PO Box 19
                        Cooranbong NSW 2265
           or
      Email: gwen.wilkinson@avondale.edu.au

Also attached is a 'glossary of symbols' to help you understand some of the content in the transcript.

I would like to thank you very much for your participation in my study and the time you have given to it. I greatly value your contribution.

Regards

_____
Ms Gwen Wilkinson
Researcher

Appendix XIX

Conference / Seminar / Workshop Papers Presented from this Work
(External to the University of Newcastle)

Wilkinson, G. (2001). The ethics of power in decision-making: Implications for nurses. Paper presented at the *Health Ethics Futures: Multidisciplinary Conversations Conference, July 25-27, 2001*. Hamilton Island, Australia: Royal College of Nursing, Australia.

Wilkinson, G. (2003). Ethical principles that apply when researching ethically challenging situations in clinical nursing. Paper presented at the *Clinical Decisions, Ethical Challenges Seminar, August 21-22, 2003*. Noosaville, Australia: Australian Resource Centre for Hospital Innovations.

Wilkinson, G. (2004). Analysing qualitative data: analysis & grounded theory research. Paper presented at the *Research from the Ground Up Workshop, February 26, 2004*. Avondale College (Sydney Campus), Wahroonga, Australia: Royal College of Nursing, Australia (Sydney Chapter).

Wilkinson, G. (2007). Protecting client autonomy: A grounded theory of the processes nurses use to deal with challenges to personal values and beliefs. Paper presented at the *ICN Conference - Nurses at the Forefront: Dealing with the Unexpected, May 27-June 1, 2007*. Yokohama, Japan: International Council of Nurses.